FACTORS INFLUENCING THE FUNCTIONALITY OF COMMUNITY HEALTH COMMITTEES: A CASE OF MOMBASA COUNTY, KENYA

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE CONFERMENT OF THE DEGREE OF MASTER OF SCIENCE IN HEALTH SYSTEMS MANAGEMENT

OF KENYA METHODIST UNIVERSITY.

SEPTEMBER 2021

DECLARATION

*"*This research thesis is my original work and has not been presented for a degree in any other university."

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DEDICATION

I dedicate this study to all the Community Health Volunteers in Mombasa County whose commitment and determination has greatly contributed to community empowerment and enhanced access to health care.

ACKNOWLEDGEMENTS

I am greatly indebted to my supervisors Mr. Musa Oluoch and Mr. Ben Onyango-Osuga for guiding me through this write-up and their contributions are highly appreciated. I would like to express my gratitude to my family for their support and encouragement during the entire period of my study. My sincere appreciation is also extended to Dr. Khadija Shikely, the Chief Officer, Department of Health, Mombasa County who is my immediate supervisor for granting me time to be away from my work station while preparing this work.

ABSTRACT

The achievement of better health outcomes is generally believed to be possible to secure through the development and support of health systems. In 2006, Kenya launched a strategy focusing on the health of communities in a bid to deliver crucial health packages. Community Health Committees consisting of selected community membership coordinate activities regarding the health of the community on behalf of their community, and have been identified as a useful health governance structure offering oversight and leadership in the execution of services related to the communities. Despite the investment in expansion of community health services in Mombasa, a number of challenges exist regarding the functionality and sustainability of the Community Health Committes. The study's central objective was to assess the factors influencing the functionality of Community Health Committees in Mombasa County. Specific Objectives were: to examine the role of communication, to assess the effect of composition, to examine the role of training and to assess the role of support supervision in influencing the functionality of Community Health Communities in health service delivery in Mombasa County. The study adopted a descriptive cross-sectional research study design. The target population was 271 community health committee members in the six sub-counties in Mombasa County. Stratified random sampling was used to identify the 162 respondents in selected Community Health Units. The research instrument used in the study was a questionnaire, additionally Key Informant Interviews were administered to six key informers within the to understand their perception, understanding and knowledge of functionality of community health committees. The questionnaire was pre-tested in Kwale County to ascertain its accuracy before the main data collection exercise begun. Descriptive and inferential statistics was used to summarize the data. The findings established that communication, composition, training and support supervision had positive and significant influence on functionality of Community Health Committee. The study further established that information flow in most health committees was poor with only 32.7% of the community members attending the community dialogue days. The health committees are not properly composed with 96% having less than the requisite committee membership. While the majority (95%) of the committee members had undergone training, the scope of the training they received did not adequately cover all the skills they needed to perform their roles. It was also established that there was inadequate follow up training with only 43.9% having received any additional training. The study also established that support supervision was inadequate and infrequent with only 50% of the health committees reporting that they have been supervised. The study concluded that community health committees where there was effective communication, proper compositions, had undergone effective training and were properly supervised had better functionality and improved governance. The study recommends that the County Government should ensure that communication, composition, training and supervision are properly managed in their various Community Health Committees to realize better functionality in community health service delivery.

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ABBREVIATION AND ACRONYMS

CHAG	Community Health Action Group
CHC	Community Health Committees
CHVs	Community Health Volunteers'
CHWs	Community Health Workers
CPHC	Comprehensive Primary Health Care
ESA	East and South Africa
HCC	Health Care Committee
HCAC	Health Centre Advisory Committee
HFCs	Health Facility Committees
HCMC	Health Centre Management Committee
HFGCs	Health Facility Governing Committees
KEPH	Kenya Essential Package for Health
MDG	Millennium Development Goals
PHC	Primary Health Care
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

This chapter mainly outlines the background of the study, the problem statement and the purpose of this study. A description of the main and specific objectives for the study is provided. Finally the section outlines the research question, justification the limitations, significance as well as the main assumptions of the study.

1.1 Background to the Study

Developing nations have unacceptably low health outcomes, yet the continuous high levels of inequalities within health status is a challenge attributed to a failure of health systems (World Health Organisation [WHO], 2007). The achievement of better health outcomes is generally believed to be possible to secure through the development and support accorded to health systems. Health systems governance and leadership is perhaps very complicated though a vital pillar within systems of health. It is about enabling the existence of a framework geared on strategic policies and combining it with accountability, systems design attention, incentives provision and regulations, building of coalitions and oversight (WHO, 2007).

The primary health care approach, identified as the key to health for all, was developed in Kenya in 1980 but it existed within health facilities and included little participation from the community. In 2004 however, Kenya evaluated its framework regarding policies of health as they were generally registering a decline of indicators associated with health. Consequently, in 2006, a strategy focusing on the health of the community was developed. The strategy that focused on community health services (CHS) to offer essential health package to Kenyans (KEPH) was described in the 2nd strategic plan

(Ministry of Health [MOH], 2007). The KEPH introduced six levels for provision of health services with referral hospitals at the 6th level while units in the community were the 1st level.

The strategy on community health was designed to encompass: the creation of a unit associated with community health that provides services to about 5000 locals; having a group of properly trained volunteers providing community health (CHV) with each offering care to 20 houseunits; each extension worker providing supervision to about twenty five CHV; and making sure the management and recruitment of CHV is performed by committees providing community health (Ministry of Public Health & Sanitation [MOPHS], 2012). Over the last decade, experiences have shown that in a setting of limited resources, interventions of health focused on developing an individuals capacity as well as that of a community and of an household are suitable for providing self care, prevention and care seeking behavior that is effective in enhancing outcomes of maternal, newborns and child health (Wangalwa et al., 2012). These interventions are capable of tackling the cultural and social basic effects of decision making delays in seeking skilled care from health institutions. The literature infers that the structure of the committee associated with health is an official approach for strengthening health systems and improving health (McCoy et al,, 2011). Committees of health have been established to be crucial structures of health governance and identified as ways in which participation of the community can be attained within intitutions providing primary health services (Loewenson, 2000a; Padarath & Friedman, 2008). A strong argument has been made that expanding the space of making decisions within health systems at lower tiers, as well as involving citizens in setting priorities, enhances the health systems responsiveness (Cleary et al., 2013). The intention of health committees is to act as a link between the

communities served and the services of health. One of the important rationales of participation by the communities is the benefit of listening to knowledge from the locals and allowing people to identify their individual needs. Evidence is building alluding to the idea that considering knowledge from locals through the participation of the community is having a positive influence on the systems of health. Studies have alluded that participation of the community on health matters has the likelihood to positively influence delivery of health services and indeed health. It has been demonstrated by Glattstein-Young (2010) that certain health committees are capable of fronting delivery of improved services and right to health. It was concluded by Padarath and Friedman (2008) that the participation of the community offers a chance to members of the community and healthcare staff to be productive stakeholders in tackling health needs of locals. In spite of the possible influence, participation by the community is surrounded by challenges and in some instances its limited and ineffective. Several researches have alluded that in Africa, health committees are not optimally functioning (Padarath & Friedman, 2008).

Community Health Committees are required to offer oversight and leadership in the execution of health services in the unit within the community. More particularly, the expectations of CHC is to provide oversight for the work done as per CHV plan coordination and mobilization of the members of the community for dialogue on a monthly and action days on a quarterly basis as well as developing the community unit yearly work plan, resource mobilization for application of activities regarding health of the community and cooperating with health committee relating to the management of facilities on matters regarding the health facilities in the locality (MOPHS, 2012). The duties of the Health Committee begins with creating a community which is informed by together establishing their strengths and needs and providing support to the health

committees in performing their function of voicing the needs of the community and presenting their priorities as they engage with health services. The problems and experiences of the communities are highlighted by the health committee together with remedies through jointly creating and executing the budget and plans of the health systems at the community level and in primary care. In many countries, however, their duties are not well stipulated, eroding their functioning and legitimacy. A functional community health committee would ensure that there is strong governance for the community unit for effective delivery of health outcomes. This study therefore aims to assess the factors that influence the functionality of the CHC.

1.2 Statement of the Problem

The approach of focusing on the community in providing health is being recognized as a productive strategy of enhancing the delivery of healthcare and tackling the heavy disease burden (WHO, 2008). Several studies have alluded that in Africa, health committees aren't optimally functioning (Padarath & Friedman, 2008). In Kenya, there still exists a wide gap in the execution of community approaches with observable discrepancies in functionality of community units across the country (Ager et al., 2016).

Kenya, just like many other nations in the globe, is endeavouring to achieve a health coverage which is universal in nature as part of their goal to sustain development. This focuses on making sure that no person is forgotten and that everyone within its population is able to access quality healthcare services. In 2018, community units providing health services to the community were evaluated. They showed that community health services coverage in Kenya is at 59%. It reported the lowest coverage of 17% in the counties of Wajir, Nandi, Mombasa and Laikipia (MOH, 2020).

Mombasa County has strived to broaden the coverage on community health programmes and currently 43 community health units have been established, despite the investment a review of key health indicator performance for the financial year 2018/2019 and 2019/2020 indicate a declining trend of healthcare services . Facility based maternal deaths increased from 69 to 74, number of children fully immunized reduced from 79% to 78%, skilled birth attendance reduced from 77% to 71% and number of TB patients completing treatment reduced from 96% to 77% (County Government of Mombasa , 2020).

To achieve a sustained high coverage of quality services requires that each element of the community unit is working effectively and that the interactions and support between each of the elements are fully functional. This study aimed at evaluating the elements affecting functionality of the Community Health Committees in health service delivery in Mombasa County. The situational elements that affect performance of CHC providers in Mombasa County were identified and documented.

1.3 Purpose of the study

The main objective of this study is to determine the factors influencing the functionality of Community Health Committees in health Service delivery in Mombasa County.

1.4 Specific Objectives

i. To examine the role of communication in influencing the functionality of Community Health Committees in Service delivery in Mombasa County.
ii. To assess the effect of composition in influencing the functionality of Community Health Committees in service delivery in Mombasa County.

iii. To establish the role of training in influencing the functionality of Community Health Committees in Service delivery in Mombasa County.

iv. To explore the role of supervision in influencing the functionality of community health communities in service delivery in Mombasa County**.**

1.5 Research Questions

i. What is the role of communication in influencing the functionality of Community Health Committees in services in Mombasa County?

ii. What is the effect of composition in influencing the functionality of Community Health Committees in services in Mombasa County?

iii. What is the role of training in influencing the functionality of Community Health Committees in services in Mombasa County?

iv. What is the role of support supervision in influencing the functionality of Community Health Committees in services in Mombasa County?

1.6 Justification of the Study

One of the strategic priorities for Mombasa County is to increase demand for quality services by strengthening community health services and reducing socio-cultural barriers (Mombasa County health and investment strategic plan 2017-2022). Towards this 43 Community Health Units have been established with a total of 1397 CHV and 271 CHC members. However, review of health specific age indicators show worsening or stagnation of the situation of health in Mombasa County. Comparison of impact level indicators between the National averages and Mombasa County shows that the latter is performing poorly. Neonatal, infant, under-five and maternal mortalities are all above the national average.

The policy goal for CHS is to empower the community to achieve the top most health standard. To achieve a sustained high coverage of quality services requires that each element (i.e. community, CHV, CHC, CHEW and health facility) is working effectively and that the interactions and support between each of the elements are fully functional.

Previous studies have indicated that there are gaps in the implementation of CHS (Ager et al, 2016). No study has been conducted in Mombasa County on the functionality of CHC as governance structure for Community Health Strategy. This study sought to assess the functioning of the CHCs as governance structure for the Community Health Service delivery in Mombasa County. The findings and recommendations from this study can be used to develop appropriate policies and guidelines for programming of community health service delivery.

1.7 Limitation of the study

Not all elements that may impact the functionality of Community Health Committees were assessed in this study. The study's specific objectives was to examine the role of communication, the effect of composition, the role of training and role of support supervision in influencing functionality of CHC. Some CHCs had dual roles and also served as Community Health Volunteers (CHV), this could affect their perception and response in some of the statements in the questionnaire.

1.8 Delimitation of the study

The study was conducted in the six sub-counties in Mombasa County. Each of the sub-County had a separate team managing health in the sub-counties, which coordinated health service delivery at all levels.

1.9 Significance of the study

This study is important as it seeks to assess the functioning of the CHCs as governance structure for the Community Health Service delivery in Mombasa County. The findings will serve to shed more light on how the Community Health Strategy can be strengthened to ensure improvement in health and to promote development and achievement of universal health coverage. This will be useful to institutions that use the concept of Community Health Strategy as a means to improve access to health care. The results of the research will also contribute to the body of knowledge and can help the County Government on policy formulation, while rolling out the community health strategy as is envisaged in the Mombasa County Health Strategic Plan 2017-22.

1.10 Assumptions of the study

The major presuppositions within this research are that participants truthfully and correctly answered the questions and that the settled sample size represented the population in assisting to generalize the outcome.

1.11 Operational Defination Of Terms

Community Health Strategy (CHS) – it is the means by which communities and households assume a vital role in health and issues related to health. The community health model is premised on the concept of comprehensively offering primary health care and anchors on concepts of health care access, empowerment, participation of the community and partnership.

The Community Health Unit (CHU) – includes households organized in operational sublocations and villages officially recognized within Kenya's system of health as first tier. A sizable population is served by the CHU and receives support from an established

number of extension health workers from the community (CHEW) and health workers from the community (CHV) premised on factors such as the density of the population. A health committee from the community governs the CHU, which is associated with primary institutions of health care which provides the CHU with the support for executing its activities.

The Community Health Assistant (CHA)/ Community Health Extension Worker – is a county government employee who is officially employed hence linking the local facilities of health with the community. The CHEW is directly answerable to the one incharge with the link institution and is supervised directly by the MOH within the sub-county and the health coordinator within the community in that particular cub-county.

Community Health Committee (CHC) – includes representatives from the communities who have the responsibility of leading actions related to the communities health at the Community Unit level. They encompass representatives from interest groups within the community, members of HFC, CHW (one being the treasurer), CHEW (secretary and technical advisor).

Community Health Worker (CHW) – employees living among the served community, who are picked by the community, accountable to them and also being provided with well defined training and not particularly formally attached to any facility (Community Action Network, 2009).

Community Participation – a process of socialization of those with shared needs among particular groups, within particular geographical locations, actively seek to establish their needs, make decisions and determine ways of meeting these needs.

Communication- the utilization of different approaches in informing and shaping decisions of the community and those of individuals in enhancing their health.

Composition- refers to the various interest groups selected by the community to represent them in the Community Health Committee. The interest groups include religious, women, people with disability and youth.

Supervision – Supervision of providers of health care contributes to improvement in their performance and retention in community health services. The approach involves dialogue between supervisors and supervisees to establish clear goals and identify solutions to problems, emphasizing the interpersonal nature of supervision, through joint problem solving and action planning.

Functionality- refers to the capability of producing a desired or expected outcome. A functional community health committee is one that is accountable to the community, has good management skills, and is both involved and participates in governance.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This literature review chapter sought to contextualize factors that influence the functionality of Community Health Committees as governance structure for community health services. The chapter starts with theoretical literature review, covering theories that are related to this study, and that resonates with the study variables. Then empirical literature follows. The review has been compiled from a wide variety of sources, including peer reviewed articles reports from organizations and scholarly libraries on the area of health governance structures particularly in developing countries, as well as grey literature on the topic. In addition, the researcher presents the conceptual framework showing how the variables are correlated. Further, the chapter presents the research gaps that informed the execution of this study.

2.2 Community Health Strategy Concept

The approach of focusing on the community when providing health has globally been recognized as a productive means of delivering improvements in the delivery of healthcare as well as in tackling the heavy disease burden and therefore contributing to the health and socioeconomic development (WHO, 1978; WHO, 2008). The community health strategy was a major support base of the primary healthcare strategy embraced by nations according to pronouncements in 1978.

In a bid to increase accessibility to affordable and equitable health care within Kenya, the health ministry in 2006 launched a strategy aimed at providing health to the community. The health ministry through this strategy acknowledged the communities as bedrock of

health systems (MOH, 2006). The approach aims at empowerment of communities in engaging in the provision of services related to healthcare. Units within the community are the functional structures for delivering services related to health. The geographical demarcation of these units have been described in accordance with administrative units which are known as sub locations. Every unit within the community is associated with a facility providing primary health care (a health center or a dispensary). Health services in the community (referrals, follow ups, promotion of health and education on health) within every unit in the community are offered by volunteers in community health and are managed by community health assistants. These are technical health staff recruited by the government to harmonize services of community health within all the units in the community. Services regarding health of the community are delivered by every unit within the community with the oversight provided by the community health Committee.(Karuga et al., 2019).

Members of the CHC are often leaders and people with influence including youth leaders, leaders of women groups and village elders. Members of the community nominate between 11 to 13 members of CHC who take part in public forums known as barazas. They provide oversight and leadership in the execution of services related to the community health within the units in the community. Particularly, the expectations of CHC's are to provide oversight for the done work by CHVs such as planning, coordinating and supporting members of the community on a monthly or quarterly basis so that the units within the community can develop a yearly work plan regarding health, supporting resources for executing activities related to health of the community and joining forces with management committees within health facilities on matters regarding health for the locals (MOH, 2012).

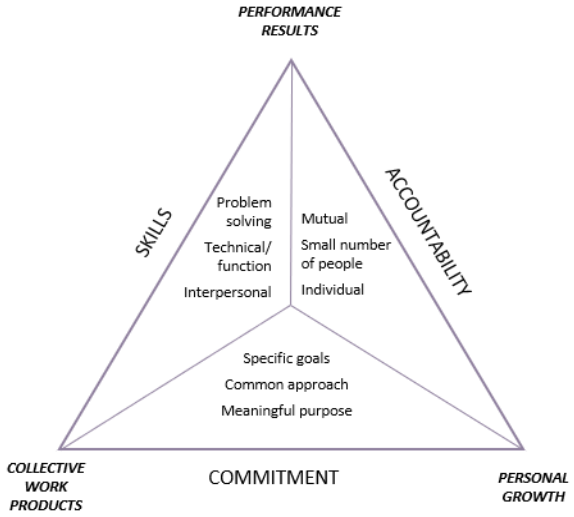
In Kenya, health units within the community became widespread by 2012. The health ministry together with other partners then struggled with the shared problem of measuring and managing the operations of the health units within the community. The entire country has grappled with this problem because the health units within the community were created without a shared standard being decided for making them functional (Ager et al., 2016).

2.3 Theoretical Framework Review

There are a number of theories on effective team models. Goals Roles Processes and Interpersonal relationship (GPRI) framework for the effectiveness of a team was proposed in 1977 by (Rubin et al., 1977). So that a team could be effective, it required four parts: Goals are well defined objectives, Clear roles of team members: with well-defined responsibilities and competencies (developed through training), Processes: well defined decision-making processes, Interpersonal relationships facilitated by good communication. In 2001 a model was proposed by Larson Carl and LaFasto Frank to tackle the issue of team effectiveness, they emphasis on skills and composition of team members. In a book authored in 2002, a model was proposed by Hackman Richard that rotated on five requirements that increased the likelihood of the effectiveness of a team. They underscored the importance of providing a structure which was enabling, that allowed for teamwork with supportive conditions in the organization. Katzenbach and Smith (1993) unveiled their model of efficient teams in a three point deliverable consisting of commitment, Skills and accountability.

Figure 2.1

Effective team Model (Katzenbach and Smith Model



Source: The Wisdom of Teams .(Katzenbach & Smith, 1993).

Therefore the variables used in this study relate to Communication, Skills (training), team Composition and supportive supervision.

2.4 Empirical Literature Review

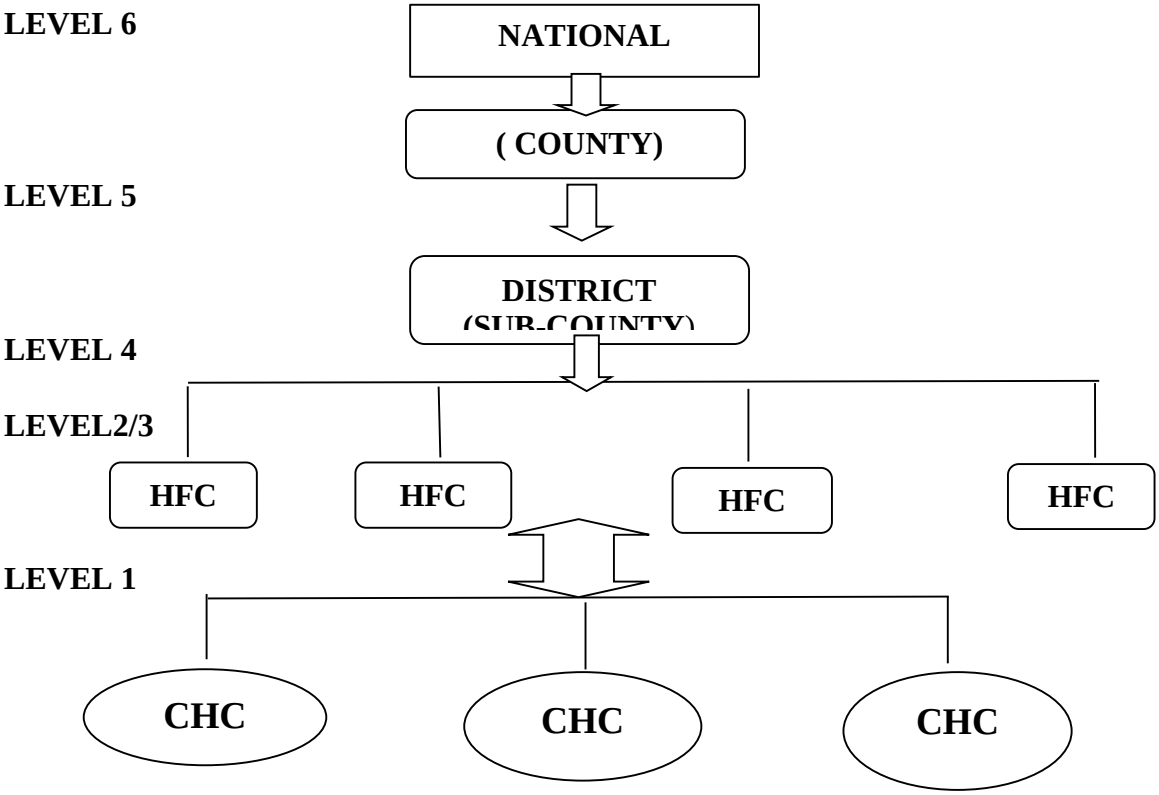
Health centers committees are known by various terms within ESA and thus this study will interchangeably refer to them as Community Health Committee or HCCs. They are common structures providing services of health at the first level within the system of health, delivering within the catchment location within the facilities primary level (particularly known as health centers or clinics). They offer engagement in the operation of health facilities and activities of PHC, to include communities in the execution and planning of health services and actions of health and in supporting accountability within public health.

Experience shows that the attainment of the millennium development goals (MDG's) needed nations to participate in collaboration to enable execution and strengthen active

involvement of the community in programs focused on attaining targets of MDG's. Additionally, in acknowledging the approaches of community health as a way of providing all with health, the deteriorating indicators of health in Kenya required the creation of an approach to deliver services at the level of houseunits and rectify the downward trajectory of health indicators. This was pronounced in the 2nd strategic plan regarding the health sector of the nation (NHSSP II) formally initiated in 2005.(MOH, 2005). The Community Health strategy (CHS) was hence initiated as a way of providing essential health packages in Kenya (KEPH) described within NHSSP II. It resulted in six level cohort in the provision of health services, with referral hospital being in the 6th level while units in the community being in the 1st level.

Figure 2.2

Administrative Structures in the Community Health Strategy



CHC = Community Health Committee HFC = Health Facility Committee

Malawi and Kenya offer HCC's within its national strategy of health, including the 2011-2016 strategic plan by the health ministry. The government of Kenya formally development in 1998 committees for health facilities (Opwora et al., 2009) and recently it developed policies regarding committees for providing health to the community in strengthening PHC (MOPHS, 2012). CHC is among the two forms of health committees focused on the communities in Kenya. Another health committee focused on the community is the management committee for health facilities, which has the oversight role in the delivery of health services focused on the facility (Waweru et al., 2013).The establishment of CHC's as the iniyial structure of a community unit takes place prior election of CHV's. Members of the CHC are often leaders and people with influence including youth leaders, leaders of women groups and village elders. Members of the community nominate between 11 to 13 members of CHC during public forums known as barazas. They provide oversight and leadership in the execution of services related to the communities health within the units in the community (MOH, 2006).

In Kenya, Community Health committees provide governance and leadership in executing matters related to health services within the community unt at the 1st level of care. (MOH, 2006). Particularly, the expectations of CHC's are to provide oversight for the activities of CHVs such as planning, coordinating and supporting members of the community on a monthly dialogue or quarterly action days so that the units within the community can develop a yearly work plan regarding health, supporting resources for executing activities related to health of the community and joining forces with management committees within facilities of health on matters regarding health facilities within the locality (MOH, 2012). A functional community health committee would

ensure that there is strong governance for community unit for effective delivery of health outcomes.

In Namibia, health committees focused on providing health to communities establish and align the communities health needs; enable the determination of, direct, strengthen and inspire workers providing the community with health services; assist and support CHW and activities regarding healthcare at the primary level and support the delivery of services; and organize activities related to health at the level of the community. They mobilize resources and deliver inspiration to community health practitioners providing health services.

In South Africa the Health Centre Committees have specific duties of oversight. They provide a care package for primary health and ensure adherence, as well as basic standards and practices within facilities of health and oversee and report the level at which the health institution is delivering and attaining indicators of health as well as set goals of primary care, such as compliance to timing set for closing and opening health facilities. They provide oversight in the efficacy of communication provided to communities and the level at which the administration of facilities of health tackle and settle the complaints brought to it by the community (Pradath & Friedman, 2008).

HCC's in Zimbabwe enables individuals to establish their needed health actions, problems and make arrangements in marshaling resources, organize and administer the contributions of the community for the health activities of the community. They operate as a pathway for health information to be directed from the district to the community and back (Loewenson, 2000). It seems that in as much as the existence of HCC committees in

a number of countries is in the form of policies, across ESA countries, they widely vary when you consider their functionality, activities and presence (Loewenson et al., 2014)

The duties of HCC start with the development of a community that is informed – making sure that the community becomes literate of their health, reviewing the experiences of the members of the community together with their perception on enhancing health, and bringing together various social groups that exist in the community. They share key information on risks to their health and breach to their right to health and on steps taken to correct this, even by health services. This strengthens and develops the support for HCC's in their important duty of acting as the voice of the community by advancing their priorities, actions and needs so as to enhance health by engaging with healthcare services (Loewenson et al., 2014).

Further, the solutions, problems and experiences of the community are tabled by HCC's within the system of health, in order for community representative together with the health staff to jointly develop and execute the health systems budget and plans at the primary care level. The joint governance role provides information to HCC's as well as motivation, and legitimacy to the communities to enable discussion and debate on plans to mobilize social activities and inputs, to collaborate with local bodies and to develop constructive associations and enable discussion with various stakeholders to make sure that the challenges pinpointed are tackled and the implementation of the health actions undertaken. Where bottlenecks or weaknesses exist in the execution of a systematic series of roles, HCC could be more reactive instead of becoming proactive in their operation. In particular, when their capability is limited to meaningful participation and community involvement, they can become reactive to political and technical lobbies. This can hinder

their ability to tackle the imbalance of power between the actors and the communities within their health system or to productively engage the community in vital activities of health systems. While community members can be assured of raising the needs of the community, they cannot have similar assurances in tackling issues of funds and budgeting, resulting in imbalances of power in the discussion of planning and budgeting (McCoy et al., 2011).

2.5 Role of Communication and functionality of Community Health Committees

Community Health Committee members are responsible for collecting community level data from the CHV for monitoring and evaluation of community activities on health, they also mobilise the community to attend days for the community to dialogue where there is regular monitoring of utilized information in the development of participatory spproaches in the promotion of healthy behavior at the community level. Within the setup of health facilities, communication is among the key tools in the provision of better care for patients and in enhancing their satisfaction as well as for passing information within the CHC. Communication is therefore pivotal in the organization's success. In moments of change within an organization, communication is considered to be a key element in the effective execution of that change (Mpembeni et al., 2015).

Nevertheless, one particular challenge for several modern institutions is lack of effective change communication (Sakeah et al., 2021). Lack of effective communication when instituting change is indicated to negatively affect the manner in which an institution functions. In particular, when change is ineffectively communicated it can result in change being resisted, rumors, and promote exaggeration of the negative aspects associated with the change among the committee members (Smelzer and Zener, 1992;

Difonzo et al., 1994) including entirely acting negatively on the influence of the culture of the organization (Keyton, 2005).

An organization's internal communication is often missed as a tool of management in spite the existence of several surveys showing its important influence on employee performance and work attitude of employees and hence the overall performance of the organization. Studies have revealed that internal communication being one of the conditions of work, strongly impacts on employees performance and engagement (European Agency for Safety and Protection of Health at Work [EASHW], 2010; Yates, 2006). As a stimulator, the ability to effectively communicate provides for self motivation, fulfilment of tasks, an environment of cooperation and a social climate that is positive. Breaking communication is stressful hence disturbing the relationships at work, as well as paralyzing and discouraging associations. Hola, (2012) found that eighty percent of the surveyed personnel were in agreement that considerable effective communication together with a work team with functioning communication and adequate updates have an influence on the employees performance and behavior at work. In another study about sixty two percent of personnel were in agreement that their performance at work suffers because of the poor communication with workmates (EASHW, 2010).

Broadly, the most likely basis provided by managers regarding the cause of deteriorating communication is inadequacy of time (mostly though, it is due to issues of ignorance). Again, more likely basic investment on internal communication is indicated to be information communication and technologies, which can be accorded a lot of importance

in spite of the fact that they particularly enhance communication when correctly utilized (Hola, 2006).

In health facilities, the inadequate management of time together with insufficient funding for ICT, is the cause for many complexities resulting in poor internal communication. The communication between the team managing health at the sub county and the community is facilitated directly by CHV through the CHEWS and CHC. There are so many approaches that communication is facilitated including informal meetings, community gatherings, chiefs Barazas, facility chalk board and dialogue days. Monthly meetings are an important avenue for communication between the CHV and the CHC. However, it has been indicated that some members of the community never took part in the days for dialogue, hence hindering coordination and communication (Mireku et al., 2004). Karuga et al. (2019) revealed that CHC were mostly forgotten in the flow of information related to health together with the making of decisions which resulted in demotivation.

2.6 Composition and functionality of Community Health Committees

The configuration, functions and duties of HCC's differ across ESA nations. Though many share basic features, they all have members numbering 9 to 15 with a health worker and community members; composed of a treasurer and secretary, vice chairperson, chairperson and a bid to include a woman for gender neutrality.

The health committee composition may influence their delivery capabilities in terms of their roles, as they present various interests and skills to the committee (Loewenson et al., 2014). The constitution of the local committee is vital in the successful results. Members of the committee can be people of influence in the community with respectful image and who are capable of expressing the interests of various sections of the community. When

the committee projects the specific interests of just a small number of people, the entire programme can lose confidence, resulting in failure.

Preferably, the committee's constitution should be reflective of the community gender balance. In as much as it may not be likely to have a gender representation that is equal, due to social and cultural practices, the representation of women need to be adequate to ensure the taking of account of their concerns and to deal with their sensitive issues (Karuga et al., 2019). Even though there are various interests and skills within HCC's, they may not represent the special health needs of all the community groups. The level at which they are represented majorly relies on whether the members are appointed or elected though even those elected cannot particularly include the groups that are disadvantaged (Loewenson et al., 2014). Additionally, including groups with more health needs provides their voice in the health planning, involving members of the community with more wealth or power in the community can be perceived by the community to provide a lot of strength in tackling the imbalances in power within the engagements taking place between health personnel and the community (Loewenson et al., 2014). Also, the bigger groups provide chances for a lot of variety in membership which when well managed, results in improved performance (Murphy et al., 1998). They also provide a lot of credibility, acceptance becomes widespread, are more reliable and the decisions become implemented. Murphy et al. (1998) suggested that below six participants, reliability diminishes rapidly.

The studies establish different issues regarding whether or the manner in which HCC's cover or accommodate views from different social groupings within the community. HCC's representation is also questioned by the literature in regards to the various

interests of the community and groups (Howard et al., 2002; Jeppsson and Okuonzi, 2000) for example if they include people who are disadvantage and those who are influential (Jeppsson & Okuonzi, 2000; Ngulube, et al., 2004). Another concern raised in the literature is if HCC's members are elected, as indicated to be happening in Zambia, Tanzania, Kenya, Uganda, South Africa and Zimbabwe or if they are appointed by those high in authority (Molyneux et al., 2012).

In Kenya, HCC comprise between 11-13 members. About a third of the committee is constituted from women organizations and groups while others are drawn from faith groups at the community level, from the disabled community and the youth (MOH Kenya, 2006). In Malawi, HCC are composed of ten members who are elected by individuals within the nearby villages and have been for the past five years holding the office. There is a variation in the female to male ratio. Pensioners and civil servants who have retired make up the membership. They must have skills to provide activities related to HCC. Health personnel do not qualify to make up the membership of the Health Centre Management Committee but of the Health Centre Advisory Committee, but some HMCS have health workers (Malawi Ministry of Health [MMH], 2011).

In comparison South Africa, the HCC are composed of 15 members including treasurer, deputy secretary, secretary, vice chairperson and chairperson and an elected committee member from the community who engages with the health facilities head (Paradath & Friedman, 2008). In Uganda, Health Unit Management Committees (HUMC) comprise of nine members. The management committee in charge of the health unit in both level three and two health facilities are proposed by the health committee within the sub county and appointed by the council of the local community. The Health Unit Management

Committee encompasses a respectable individual, a medical individual managing a health unit, two public individuals who are literate, a health unit representative and an educator from a school nearby. Co-Opting can be done for the chairperson of the local council and the local chief (Poku, 2008).

In Zimbabwe, HCC are comprises of between 11-15 members. It encompasses a nominated community representative or one that the associations and institutions have elected: faith based groups, civil societies, women, youths, a representative from a particular vulnerable group; health institutions both private and public and others: police, women affairs, housing, labour, agriculture and schools. The counselor together with others within the leadership of political parties to become the committtes ex officio (Machingura et al., 2011). At a meeting for south and east African countries deliberating the region's health equity which was held in Zimbabwe in 2014, delegates recommended provision of guidance which is a flexible composition of HCC to project a diverse setup within the nation.

2.7 Training and functionality of Community Health Committees

Evidence exists that training activities are positively influencing the accomplishments of both the team and the individual (Hermann et al., 2009). As with the examples from Zimbabwe, it is therefore suggested by Loewenson (2000) that training of health committees facilitates in enhanced participation levels. It is suggested by Bjorkman and Svensson (2009) that HC's training is accelerating the maximum operations of the health system. Communication gaps or skills of information are limiting the better utilization of social abilities in projecting the needs of the community in other operations, such as when the gap in the capacity in overseeing the services is hampered by the ability to oversee

the services or feedback to the community. Particular gaps in budgeting and planning may make it challenging to tackle the imbalances in power within the relationships linking health authorities and members and impacting the manner in which members of HCC can sway decisions (Lowenson et al., 2014). He emphasized that training needs to be invested on incoming members of that institution in regards to managerial tasks and health planning. Even though proper skills required are specific to each particular project, skills are required within five key areas: evaluation of programmes, delivery and planning of health interventions, collection and analysis of health information, priority setting and problem solving and community organization. Lack of training or better put a number of skills can result in unclear comprehension of the members responsibilities and roles which can be a more pressing challenge experienced by the structure governing the health system (Seiyefa & Best 2014).

Studies indicated that literacy was impacting on the confidence of the members of HCC within their responsibilities (GlattseinYoung, 2010). Participation levels that are less or have lower were indicated to result in demoralized members of HCC (Uzochukwu et al., 2011; McCoy et al., 2011). Training approaches utilized to build capacities within HCC are diverse. Participatory methods are some of the utilized approaches in the community, while other approaches combine three or two representatives of HCC from several HCC's within the district in their training at the level of the district. The provided training has been observed to be irregular; trainers and resources are reported to be lacking; only some of the nations provide guidelines on what and how to train; challenges in providing training to a big group of HCC's; and with external funders being the ones determining what is to be trained in terms of content . Creigler et al. (2011) noted that there should be initial training to prepare them for their role and an ongoing training for update on

emerging skills, strengthening previously acquired training and making sure that the learned skills are being practiced.

Standard guidelines and utilization of protocols is more being acknowledged as a vital tool by health professionals in assuring quality (Hermann et al., 2009). Training materials are available in Kenya on basic modules regarding health volunteers in the community, a health committee handbook and manual for trainers, community health committee curriculum. When training the community on how to take health action within the groups, managers of health and members are responsible for working using CHAGS guidelines to provide the committees with the services associating referral with care (MOPHS, 2012).

In 2010 a university in South Africa came up with a manual for training committees on the health of the community by enabling the committees to comprehend and execute their roles, while the health ministry in Tanzania in 2001 came up with a training manual for management of health institutions at the district level . Zimbabwe has a number of materials for training HCC's. They include a training manual for HCC, guidance for health workers and materials for training and literacy manual for providing community health (Machingura, 2010).

Considerable research highlights the need for health committee members' capacitation to fulfill their role. A number of studies (Padarath and Friedman, 2008; Boulle, 2007; Haricharan, 2011) confirm that often committees are unsustainable due to the lack of requisite skills. Cognizance must be taken of health committee members' educational background and that they often come from 'marginalised' communities. Hence, training is of utmost importance not only to create functioning committees but also to ensure an inclusive and fair process. Chikonde (2017) noted that training Health Committees

enabled the enhancement of knowledge, awareness and competencies of the participating communities and their right to health. At the end of the training, members of health committees were viewed as being better aware and capable of undertaking their responsibilities and roles in regards to health facilities (Chikonde, 2017).

2.8 Role Support Supervision in the functionality of Community Health Committees

Supportive supervision is a procedure for coaching, monitoring and guiding personnel to encourage adherence to standard norms and guarantee the provision of quality care services. The process of supervision enables supervisee and supervisors with a chance to deliver as a team on the shared objectives and goals. Literature about supervision is filled with sentiments concerning its importance in the success of the community programs. Supportive supervision provided by community health field officers is important so as to sustain the intervention based standards within the community, such as promotion of health which is provided by CHV's (Freeman et al., 2009). The level at which the members of CHC get supervision and support from the health ministry and/or by other ways enables the CHC to deliver its mission fully as well as its objectives (Gaudrault et al., 2016).

A work environment that is enabling could be maintained and even created by a critical element such as supportive supervision (Jaskiewicz & Tulenko, 2012). There should be continuous, at minimum three monthly supervision through the utilization of tools to engage on the current challenges, data and goals at community level (Gaudrault et al., 2016). Supervision of Community Health Unit personnel needs to be undertaken continuously to offer development of skills, solving of problems, coaching and feedback (Gaudrault et al., 2016).

Detailed interviews conducted in Benin and Kenya on health workers showed that 50% of them viewed supervision as a way of offering criticism and control. They revealed that the supervision lacked feedback, was irregular and infrequent (Mathauer & Imhoff, 2006). This is also reflected in the situation in Malawi, where the challenge was regular supervision (Kadzindira & Chilowa, 2001). Boulle (2007) found that due to limited staffing, there was limited supervision and support for CHCs. A number of studies established where supervision was lacking, it was due to poorly coordinated entities which provided inadequate support (Sarfraz & Hamid, 2014 ;Teklehaimanot & Teklehaimanot, 2013).

2.9 Conceptual Framework

Four independent variables that may influence the functionality of the Community Health Committees as governance structure in Mombasa County can be identified. These are Communication, Composition, Training and support supervision. The dependent variable is the functionality of CHC in governance.

Independent Variables

Communication includes internal communication and coordination within the committee, level of communication within the committee and flow of information from the facilities of health to the community and vice versa.

Composition planning at the community level needs to take place not just with the official community representatives but together with the entire people of interests and groups. It is also essential to recognize diversity. Composition of CHC includes gender representation, youth and special interest groups, inclusion of influential and disadvantaged persons in the committee..

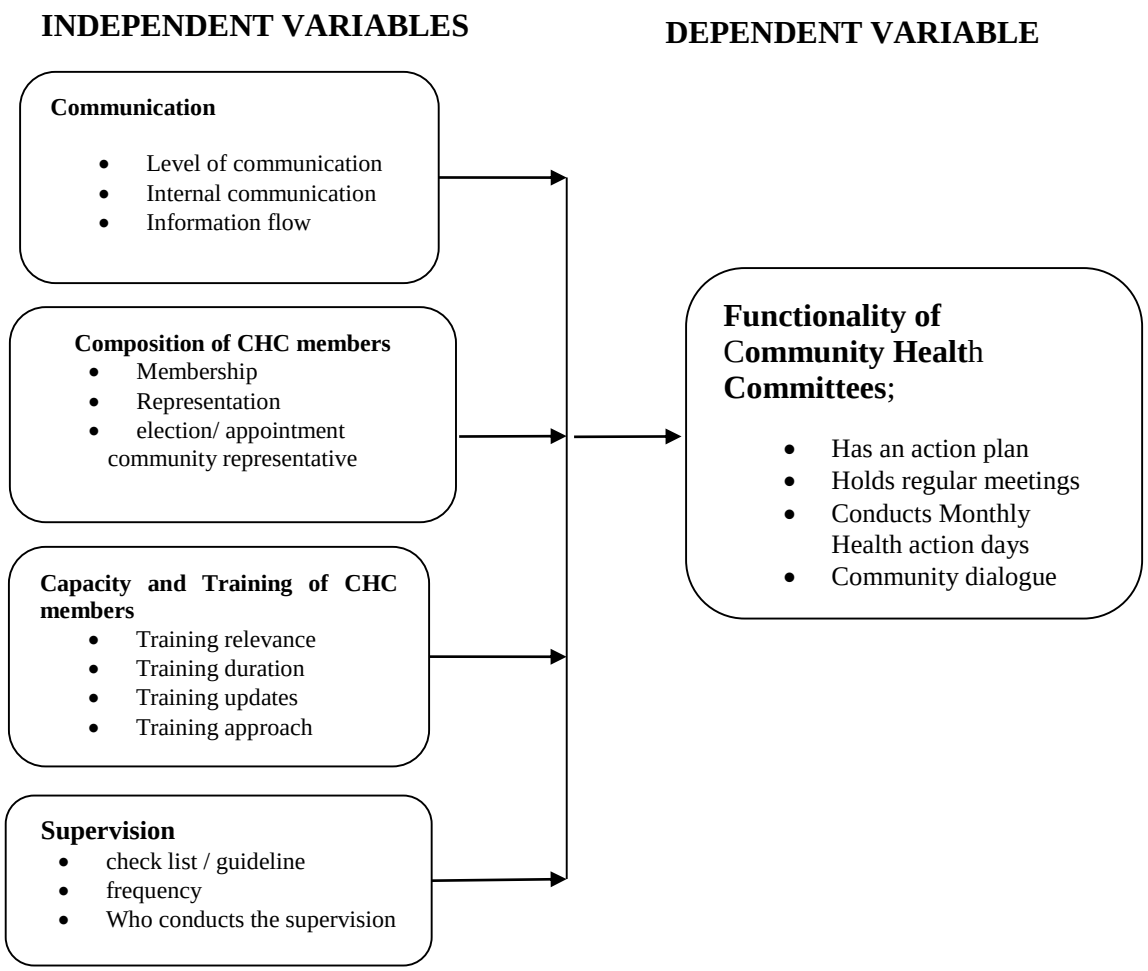
Training; The community members often do not possess the confidence, knowledge and skills to get what is of its interest and the response of public agencies is that of offering initiative for building capacity that are developed to deliver on the gaps. Training in this context refers to the type of training, training methods, content and duration of the training and the relevance of the training to the roles of CHC members and evaluation methods.

Supervision; Will determine if there is a functioning primary supervision system for CHCs and who conducts the supervision for CHC and how frequent is the support supervision. Whether there is a checklist available.

Dependable variable; AMREF Health Africa developed a unit of health within the community with a scorecard for assessing and administering its operations (Ager et al., 2016). Functionality was determined by participation and involvement in governance activities (Community health committees leading quarterly dialogue days with CHVs and community members with minutes of the meetings filed). Good skills in management demonstrated by the presence of an action plan and evidence that the community health committee meets each month and the minutes filed.

Figure 2.3

Conceptual Framework



CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter is mainly concerned with methodological description of the study in regards to how the researcher used the entire process of research. A description is provided in this section of the key areas including its design, the variables used, the study locale, population targeted, technique of sampling and size of the sample, instrument of research, study piloting process, reliability and validity, techniques for collecting data, analysis of data and considerations which were both ethical and logistical in nature.

3.2 Research Design

The study adopted a descriptive cross sectional research design to establish the factors that influence the functionality of Community Health Committees in Mombasa County. Both quantitative and qualitative methods of data collection were used. Structured questionnaire was used to survey the communication, composition, training, support supervision and functionality of the CHCs. The study utilized questionnaires having looked at its appropriateness in accomplishing descriptive studies. Questionnaires according to Creswell (2018) are provided to participants for indicating appropriate responses then collected by the researcher after their completion. Their utilization in this study was based on the little amount of time it takes for a participant to inscribe their views, as well as their inexpensive nature and their ability to ensure anonymity of the participants together with ability to be used on a wide population. (Creswell, 2018). In order to get in-depth opinion and to further validate the quantitative data, key informant interviews were conducted for health care workers involved in community strategy. The

researcher used a guide to interview the selected key informants. The study was carried out between the months of March to April 2020 for a period of six weeks.

3.3 Location of the study

Mombasa County is in the South-Eastern part of the Coastal region of Kenya. It covers an area of 229.9 Km^2 . It borders Kilifi County to the North, Kwale County to the South West and the Indian Ocean to the East. Administratively, the County is divided into six sub-counties namely: Mvita, Nyali, Changamwe, Jomvu, Kisauni, and Likoni and thirty county assembly wards. The estimated population is 1,266,358 in 2021. The study was conducted within Mombasa County in the 6 administrative sub-counties .The six Sub-Counties have different coordination teams and partners supporting Community health services, which makes each Sub-County unique. See Appendix VI for study area map

3.4 Target Population

In statistics, the targeted population is the particular population where the desired information is acquired from. Kumar (2011) defines population as a term used to represent a particular group, events, elements, services or people under investigation. The target population of the study was Community Health Committee members in selected Community Units in Mombasa County. The total number of CHCs in the County is 271 distributed in the 43 community units, thus the target population is approximately 271 respondents.

3.5 Sampling Procedure and Technique

The study adopted a stratified random sampling technique to assess functionality of Community Health Committees as governance structure for Community Health Services in Mombasa County.

.A sample, according to Polit and Beck (2008) is the subset of the elements represented in the study. The readjustment of the size of sample was conducted by considering a formula presented by Yamane (1967) as offered by Israel (1992).

$$n = \frac{N}{1 + N(e)^2}$$

Where: n= Sample size, N= Population size e= Level of Precision.

At 95% level of confidence and ρ=5

$$n = \frac{271}{1 + 271\ (0.05)^2}$$

$$n = 161.5$$

$$n = 162$$

Thus 162 respondents were used for the study.

3.6 Inclusion Criteria

All the members of the Community Health Committee and Sub-County team members who are directly engaged in administration of the units within the community in Mombasa County were included.

3.7 Exclusion Criteria

Community Health Committees who had served for a period of less than three months were excluded.

3.8 Data Collection Instruments and Procedure

Community Health Committee members who were selected using simple random sampling techniques were briefed about the study and then requested to give consent before the questionnaire (either in English or Kiswahili) was provided for filling. After

distribution of the structured questionnaire, the researcher agreed with the respondents on the most suitable duration before collecting the filled questionnaire. Phone contacts for the respondents were taken for ease of follow-up. . The qualitative data was collected using an interview guide and administered to 6 key informants who were either Sub-County community health focal person or community health assistants. The questionnaire was used in the study as it requires less time, is less expensive, permits collection of data from a wide population and respondents' anonymity ensures that they give honest answers (Kumar, 2011).

3.9 Pre-Testing of the Study

The research tool was pretested resulting in determination of its ability to acquire accurate data prior to the actual study. Proofreading ensured the tools completeness prior to testing. This ensured remedial measures were instituted eradicating ambiguities that arose prior to the actual study being conducted. Additionally, the instrument was administered while being supervised by the researcher as a means of guaranteeing its proper administration. The pre-testing was carried out on 9 respondents (5% of the sample according to Mugenda and Mugenda (2003) among CHC who were not involved in subsequent data collection in Matuga sub-county Kwale County. There was consistency in most of the responses. Two of the questions were not well framed. Based on the responses, the questionnaire was translated to Kiswahili to facilitate a better understanding of the questions by the respondents. Modification of questionnaires was done to improve their validity and reliability coefficient to at least 0.7. Items with validity and reliability coefficient of at least 0.7 are accepted as valid and reliable.

3.10 Validity of the Instruments

The statistical test and measures to assess the validity of quantitative instruments was pretest testing. Thus external, predictive and content validity was considered to ensure inferential and generalization of the instrument. To make sure the instrument was valid, the questionnaire was developed with questions restricting the participant to provide data within the study areas. Validity, both content and construct was measured through provision of supervisors opinion which proved adequate in realigning the instrument into attaining its objective. On the basis of these opinions, the tool was adjusted, through removal and addition of appropriate questions and modification of the tools structure.

3.11 Reliability of the Instrument

Reliability in reference to qualitative studies is associated with the instrument's consistency and the administration of the test. To ensure reliability, the instrument tool was administered to all respondents within the same time frame. Cronbach's Alpha was used in the internal consistency reliability test in order to explain and interpret the reliability among the items surveyed (Leedy & Ormrod 2005). Cronbach's alpha ranges from 0.0 to 1.0 and many researchers suggested 0.70 as the most acceptable and suitable cut-off point for the Cronbach's Alpha value (Kothari , 2004).

3.12 Data analysis and presentation

This is an essential step when conducting research that is scientific in nature because it guarantees the capture of suitable data that allows for analysis and comparison in social science research (Mugenda & Mugenda, 1999; Kothari, 2004). The completeness of the questionnaire was ascertained then data coded and inputted in a database. The data was then transferred to a statistical package software v 25 for evaluation. Descriptive statistics

(frequencies, percentages) was used to summarize the data. Correlation and multilinear analysis were employed to test the effect of independent variables on dependent variables. All results were considered significant at α=0.05. The analyzed data was then presented in the form of graphs, pie charts and tables for easy interpretation. The qualitative data was analyzed through thematic analysis. This was based on the emerging themes where the researcher sought to identify themes from each open-ended question and the interviews provided. Related themes were grouped together and added to support the quantitative findings. Qualitative data was presented using quotes, where the researcher quoted the interviews verbatim. The overall study results were presented at the county health management level. In addition, the results will be published in peer-reviewed journals.

3.13. Regression Model

The study aims at establishing the effect factors that influence the functionality of Community Health Committees in Community Health Service delivery in Mombasa County. The dependent variable was functionality while the role of communication [RoC], effect of composition [EoC], role of training [RoT] and role of support supervision [RSS] were the independent variables as presented in the following regression model.

$$Y_{olk} = \beta_0 + \beta_{roc}X_{roc} + \beta_{eoc}X_{eoc} + \beta_{rot}X_{rot} + \beta_{rss}X_{rss} + \ell i$$

From the equation:

Y is the dependent variable, β_0 is a constant,

β_{roc}, β_{eoc}, β_{rot} *and* β_{rss}, are the regression coefficients while X_{roc}, X_{eoc}, X_{rot} *and* X_{rss} represents the independent variables

Y = functionality

β_{roc}, = role of communication

β_{eoc} = effect of composition

β_{rot} = role of training *and*

β_{rss} =role of support supervision

ℓi is the error term

3.14 Ethical Consideration

The KeMU Scientific Ethical Research Committee (SERC) approved the study undertaking upon researcher's fulfillment of the necessary requirements. A license to conduct the research in Mombasa County was obtained from NACOSTI. An introduction letter was also provided by the University marked to Mombasa County director for health to enable the researcher to undertake the study. The County Director for Health Mombasa County issued a letter authorizing the study to be conducted. Confidentiality and privacy of the information obtained from the respondents was ensured by not including any form of identity on the data collection tools. Written informed consent was sought from the respondent after clear explanation on the purpose of the study and participation in the study was on a voluntary basis. Completed data collection tools were kept in a place accessible only to the principal researcher.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents the results and discussions. The chapter comprises of five sections, which include response rate, socio-demographic characteristics of the respondents such as age, sex, education, and descriptive analysis, correlation and regression analysis. Descriptive analysis was used to analyze how the respondents responded to various statements on the relation between functionality and communication, composition, training and support supervision. Correlation and regression analysis were employed to test the effect of independent variables on dependent variables.

4.2 Response Rate

This study administered 162 questionnaires to the selected respondents. A 100% response rate was achieved in this study. This high response rate was attributed to close connection between the respondents and the interest the study generated from the respondents. follow up on the respondents was made to ensure that they responded to the questionnaire.

4.3 Summary of the Scale Reliability Results

Table 4.1 shows the results of Cronbach Alpha reliability test for the variables.

Table 4.1

Scale Reliability Results

	Cronbach's Alpha	N of Items	Conclusion
Communication	0.774	6	scale reliable
Composition	0.75	6	scale reliable
Training	0.729	8	scale reliable
support supervision	0.822	5	scale reliable
functionality of CHC	0.781	5	scale reliable
Overall	0.771	30	Instrument reliable

The summary results presented in Table 4.1 show that communication, composition, training, support supervision and functionality of community health communities had Cronbach Alpha of 0.774, 0.75, 0.729, 0.822, 0.781 and 0.771 respectively. These finding implied that the scale used to measure these variables was reliable since their Cronbach Alpha was above the threshold of 0.7 recommended for reliability (Kathuri & Pals,1993).

4.4 Socio-demographic characteristics of CHC members

This section presents the demographic characteristics of the respondents. These include the community served, gender, age bracket and level of education of the respondents.

Community Served

Table 4.2 shows the distribution of Community Health Service providers in Mombasa County

Table 4.2

Distribution of Community Health Service providers in Mombasa County

SUB-COUNTY	existing CHU	Existing No of CHC	Field CHA	Facility CHA
CHANGAMWE	7	54	6	6
JOMVU	5	43	5	5
MVITA	9	36	9	9
LIKONI	9	86	6	9
KISAUNI	8	42	6	5
NYALI	5	10	5	4
TOTAL	43	271	37	38

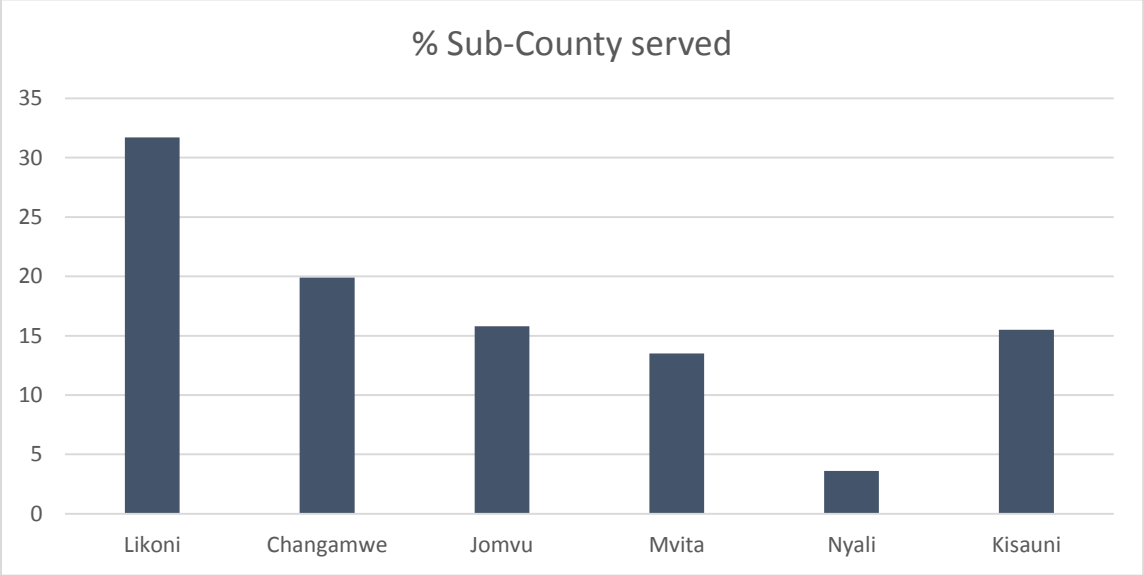
Source; County Community Health Focal Person

Mombasa County has 43 established community units with a total of 271 existing CHC members.There is a total of 75 community health assistants, both facility and field based. Likoni Sub-county and Mvita had the highest number of community units with 9 units in each. Nyali Sub-County with 5 units had the least number. Considering that each community unit initially had 11 members, Likoni has the lowest drop-out rate of 13% while Nyali has the highest drop-out of 82%.

Figure 4.1 shows that 31.7% (52) of the respondent sampled served Likoni sub county, 19.9% (32) served Changamwe, 15.8% (26) served Jomvu while another 15.4% (25) served Kisauni Subcounty. Those who indicated they served Nyali were the least at 3.6% (6).

Figure 4.1

Percentage of CHC per Sub-county

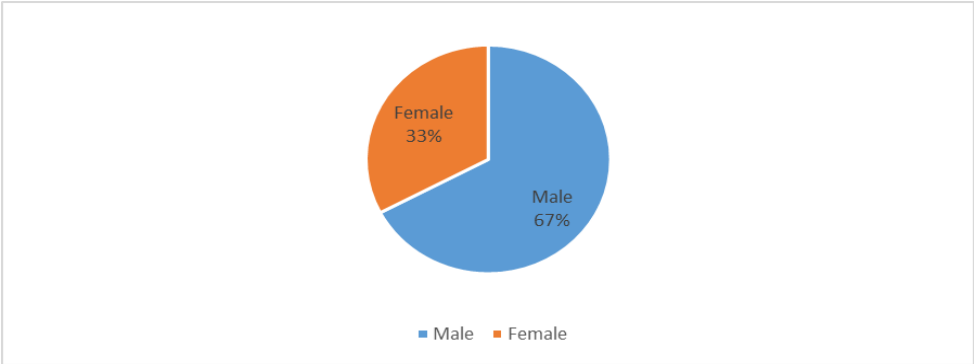


Gender of the Respondents

Figure 4.2 is a pie chart representing the gender of the respondents.

Figure 4.2

Gender of the respondents



The results presented in Figure 4.2 show that 67% (109) were male while 33% (53) were female. From the finding it can be assumed that the representation of women in the CHC is far much lower compared to men. This can be attributed to the selection criteria.

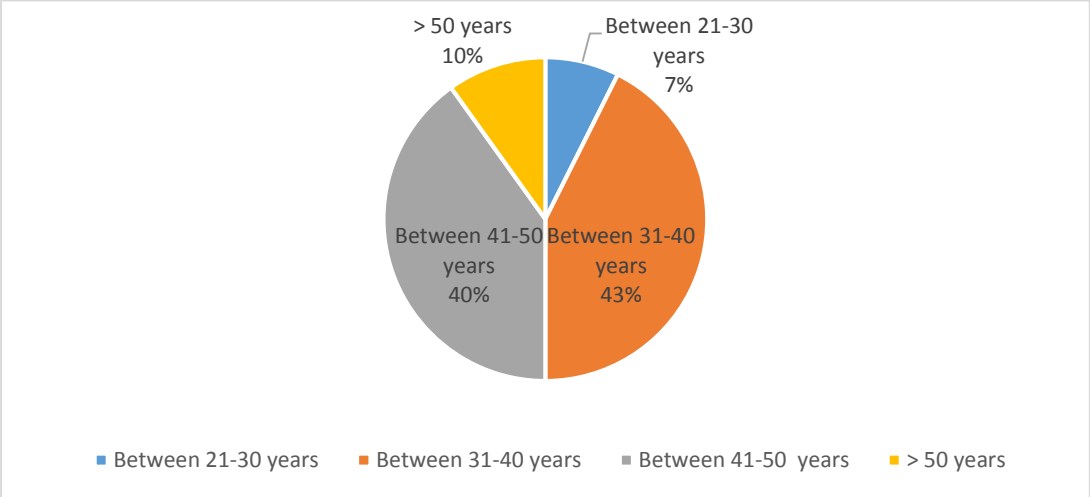
The study established that 75% of the committee members were appointed with most of the appointed members being village elders who are predominantly male.

Age Bracket of the Respondents

The respondents were asked to state their ages and Figure 4.3 presents the findings.

Figure 4.3

Age of the respondents



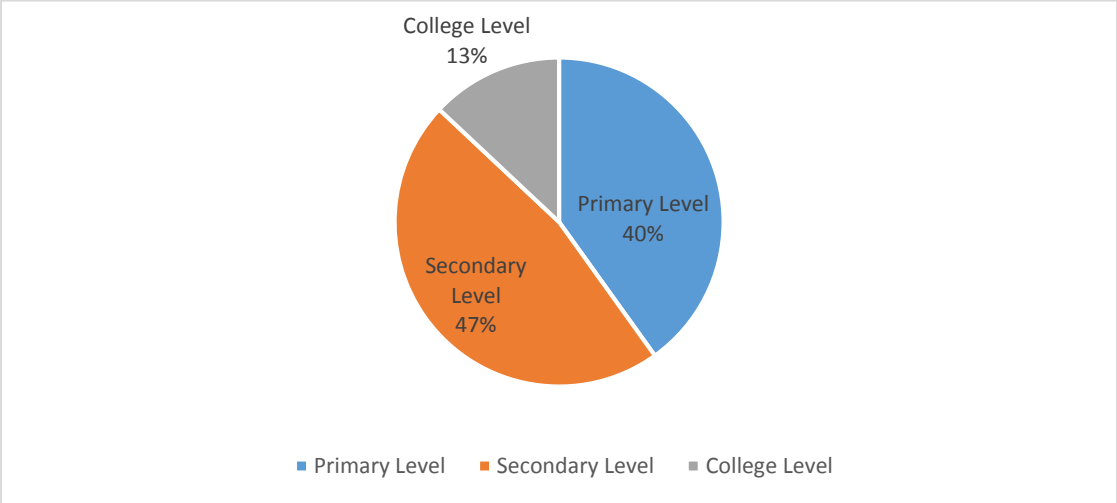
This section presents the age distribution of the respondents. The results in Figure 4.3 show that 43% (70) were aged between 31 and 40 years, 40% (65) were aged between 41 and 50 years while those between 21 and 30 and those above 50 years were 7% (11) and 10% (16) respectively. The findings implied that the majority of the members of the community health committees in Mombasa County were middle aged individuals however, the youths and old people were equally represented. The finding further implied that there was age diversity among the community health committees in Mombasa County.

Level of Education

The study further sought to establish the level of education of the respondents. Community health committees are specialized committees that require educated individuals that are able to discern the health needs of their community. The respondents were asked to state the highest level of education attained and the Findings are presented in Figure 4.4.

Figure 4.4

Level of Education of the respondents



The results show that 47% (76) had a secondary level of education, 40% (65) had primary level of education while only 13% indicated that they had college level of education. The findings implied that the majority of the members of community health committees in Mombasa County had basic education. Education is synonymous to knowledge and awareness hence educated members of the community health committees are more effective in carrying their mandate compared to less educated members.

4.5 Descriptive Analysis

This section presents the descriptive analysis which basically analyzes the respondents' feedback on various statements used in the questionnaire and in measurement of the

variables. The descriptive analysis was conducted based on each specific objective. The study used percentages and frequencies in this analysis.

Communication in Community Health Committees

The first objective was to examine the role of communication in influencing the functionality of Community Health Committees in Mombasa County. The results in this section focus on establishing the level of communication among the Community Health Committees in Mombasa County. The study also sought to find out from the respondents whether communication was useful in functionality of the Community Health Committees. The respondents were asked about various aspects of communication in the functionality of CHC and Table 4.3 represents the results.

Table 4.3

Impression of Respondents on Various Aspects of Communication

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
Communication is usefull in Functionality of CHC	17.9%	54.9%	22.8%	4.3%	0.0%
The level of communication in my CHC is good.	9.9%	38.9%	17.3%	34.0%	0.0%
I am kept well informed about my CHC activities, plans and progress	8.6%	37.0%	22.2%	32.1%	0.0%

1.Strongly Disagree 2. Disagree 3. Neither agree nor disagree 4. Agree 5. Strongly Agree

The results in Table 4.3 show that 54.9% of the respondents agreed with another 17.9% strongly agreeing on the usefulness of communication in the functionality of CHC. On the other hand 4.3% of the respondents disagreed with the statement. The findings show that the majority (72.8%) of the respondents agreed on the role of communication in functionality of the CHC in Mombasa County.

The study further sought to establish level communication in CHC (The extent to which data flows to the health system and back and the extent to which the CHC makes use of data and information to identify key health issues for action and to advocate for health The results in Table 4.3 show that 48.8% of the respondents agreed (Strongly agreed and Agreed) that the level of communication was good. On the other hand, 34% disagreed. The findings implied that not all the CHCs in Mombasa County had a good level of communication. In a key informant interview with the Sub-county Community strategy focal person:

" *They (CHV) do not share the household data with the CHC, in most cases the monthly household reports are directly forwarded to the community health assistants*.".

The results further show that 45.6 % of the respondents agreed with 32.1 % disagreeing on whether they were kept informed about their CHC activities, plan and progress . The findings indicate that internal communication within the CHC was fairly good .

The respondents were asked how the CHC pass or receive information from the community and Figure 4.5 shows the results.

Figure 4.5

How CHC passes or receives Information from the Community

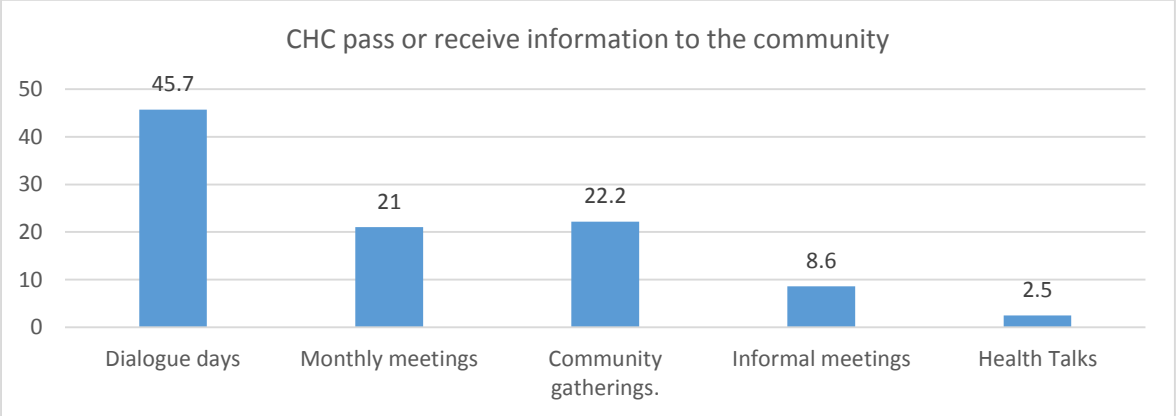
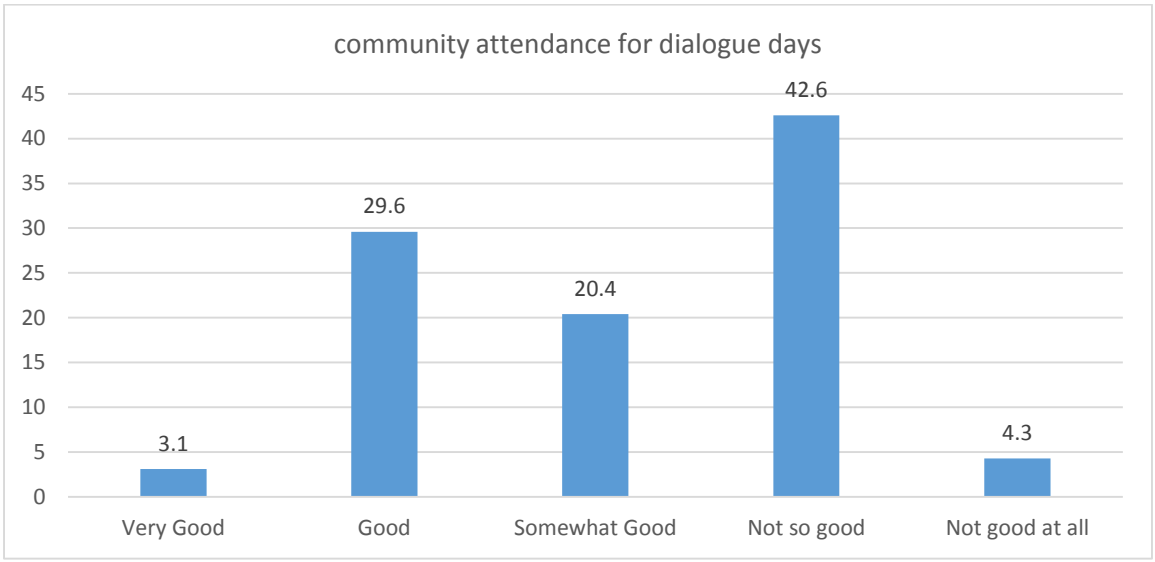


Figure 4.5 shows the different modalities through which CHC receives feedback and pass health related information to the community. The results show that 45.7% (74) indicated receiving information through dialogue days, 22.2% (36) through community gatherings, 21% (34)indicated monthly meetings while 8.6% (14)and 2.5% (4)indicated informal meetings and health talks respectively. The findings implied that CHC used various channels of passing and receiving information from the community but dialogue days was the most common among the CHC in Mombasa County.

The results in Figure 4.6 show the community attendance of dialogue days organized by CHC in Mombasa County.

Figure 4.6

Community Attendance for Dialogue Days

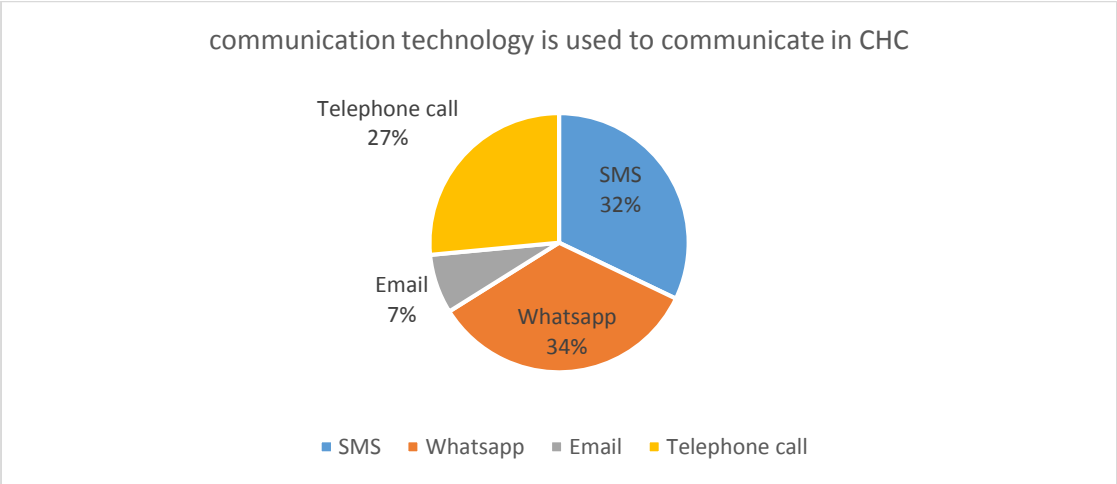


The results show that 46.9% of the respondents indicated that attendance was not good, while 32.7% indicated that the attendance was good. These findings implied that only 32.7% of CHC recorded good attendance of the community on their dialogue days.

Finally, the study sought to find the technologies used in communication among the CHC in Mombasa County. The results are presented in Figure 4.7

Figure 4.7

Communication Techniques used by CHC



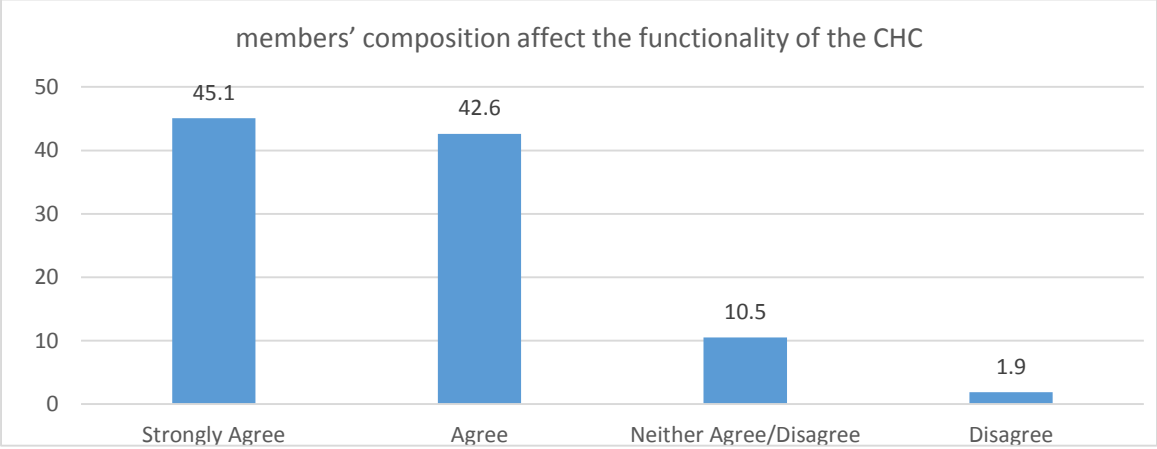
The results in Figure 4.7 show that WhatApps 34% (55) and SMS 32% 52 were the most common communication media used by CHC in their communication to members and the community. The finding implied that CHC in Mombasa use latest communication media in their communication.

Composition of Community Health Committees

The second objective of the study was to assess the effect of composition in influencing the functionality of Community Health Committees in Mombasa County. This section presents the descriptive results that analyses the composition of CHC in Mombasa in terms of members, representation and ways used in selecting the committee's members. The respondents were asked whether CHC composition affected it functionality and results presented in Figure 4.8

Figure 4.8

Whether Members Composition Affects the Functionality of CHC

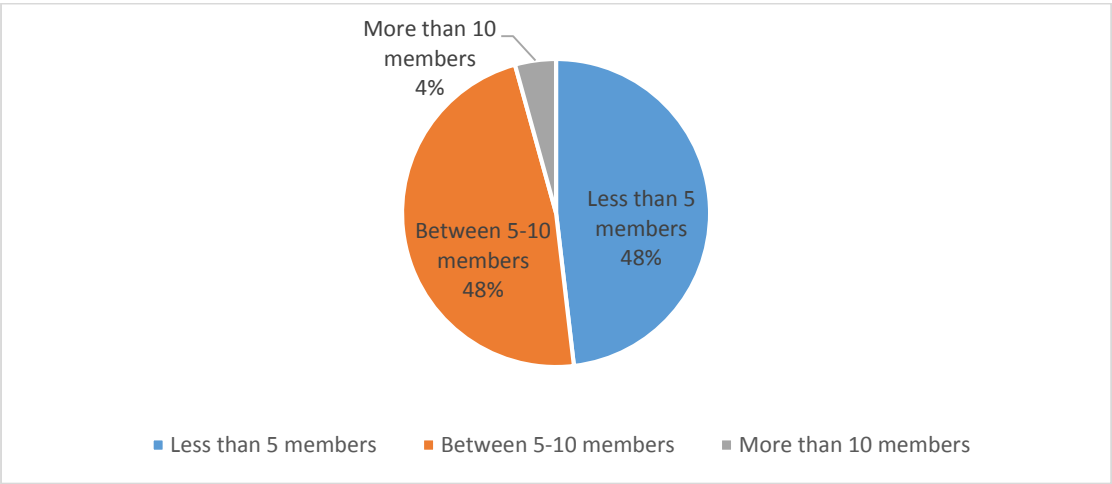


The results In Figure 4.8 show 45.1% and 42.6% strongly agreed and agreed respectively, giving a total of 97.7% agreeing. On the other hand 1.9% of the respondents disagreed. The findings implied that the majority of the respondents agreed that CHC composition influenced its functionality..

The study further sought to find out the number of members that composed the community health committees and the findings are shown in Figure 4.9.

Figure 4.9

Membership of the CHC

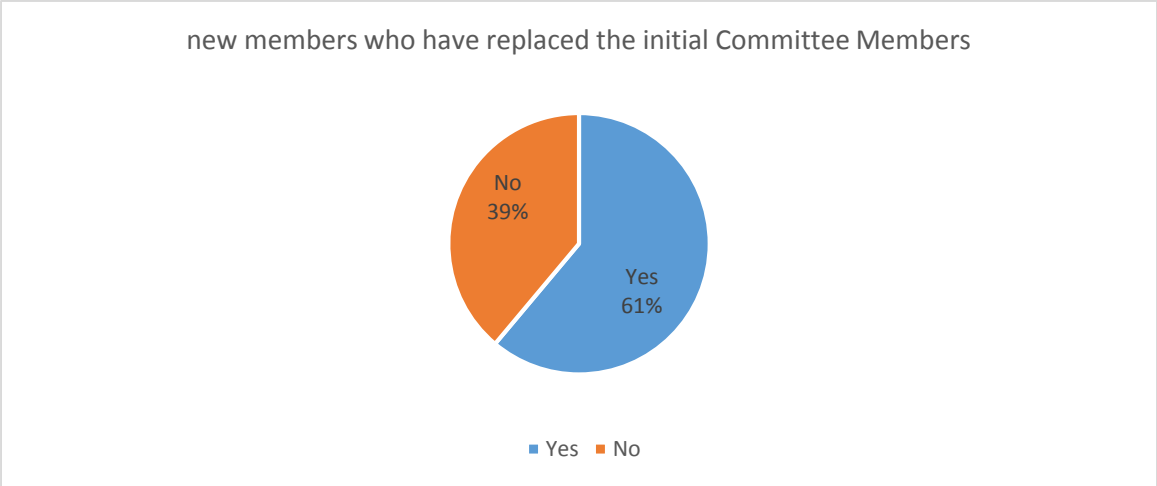


The results in Figure 4.9 show that 48% (78) of the respondents indicated their CHC had less than 5 members, another 48% (78) indicated they had 5-10 members and only 4% of the respondents indicated they were more than 10 members. The findings implied that membership of CHCs in Mombasa County varied. About 96% of the committees had less than half the recommended number of members this indicates that there was a high drop out among the Community health committees in Mombasa.

The respondents were asked whether there were new committee members who have replaced the CHC members who had left and Figure 4.10 presents the findings.

Figure 4.10

New members of CHC

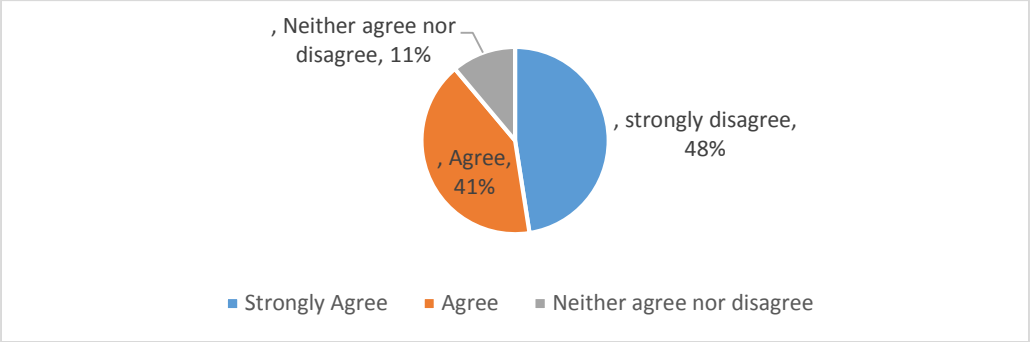


The results in Figure 4.10 show that 61% of the respondents agreed that their CHC had new members who had replaced the initial members while 39% indicated they had no new members. While some efforts are being made in some committees to maintain the recommended number of CHC by replacement, the number of members are still far below the requirement.

The respondents were asked whether their committee is representative of all interest groups and the results are presented in Figure 4.11

Figure 4.11

Whether the Committees are Representative of All the Interest Groups

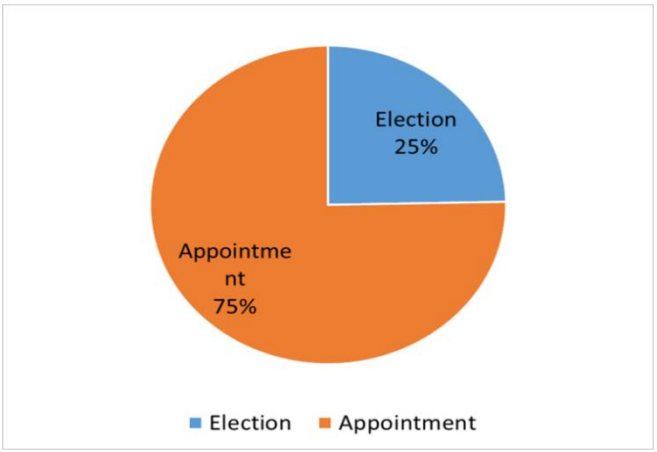


On whether the community health committees in Mombasa were representative of all interest groups, only 41% of the respondents agreed that their CHC was composed of all interest groups while 48% strongly disagreed as shown in Figure 4.11. The results implies that about half the respondents felt that their committees are not representative.

The study finally sought to find out the mode of selection of members in community health committees in Mombasa county. Findings are shown in Figure 4.12

Figure 4.12

Mode of selecting members of the CHC



The results in Figure 4.12 show that 75% indicated they were appointment in the committees while only 25% were elected. This was further confirmed during a key informant interview with a Sub-County Community strategy coordinator.

"In some of my CUs no election was done. We engaged the area chiefs to mobilize the community to elect CHC members as per the guideline. We however realized later that most of the chiefs did not conduct elections and the names forwarded were those of village elders."

In terms of composition this study established that not all the CHC in Mombasa County are properly composed due to a high dropout rate. Similarly, some CHCs are not representative of all the interest groups.

Training in Community Health Committees

The study further sought to analyze the role of training in influencing the functionality of Community Health Committees and the findings are shown in Table 4.4.

Table 4.4

Descriptive Results for Training in CHC

	Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree
Training of committee members influences the functionality of CHC	0.0%	0.0%	1.2%	47.5%	51.2%
Training approach used was participatory	0.0%	0.0%	3.1%	61.1%	35.8%
There is Continuing Education for Committee Members regarding their duties/roles	0.0%	50.6%	5.6%	38.3%	5.6%

1.Strongly Disagree 2. Disagree 3. Neither agree nor disagree 4. Agree 5. Strongly Agree

First, the study asked the respondent whether training of committees' members influences their functionality in CHC. The results in Table 4.4 show that 51.2% and 47.5% of the respondent strongly agreed and agreed respectively. This findings implies that most of the respondents(98.7%) agreed that training influences functionality

On whether the training approach used was participatory, 61.1% and 35.8% of the respondents strongly agreed and agreed respectively. Implying that the training method used was in cases participatory. On whether there was continuous education for the committee members regarding their roles 50.6% disagreed. The finding in this section implies that members of CHC in Mombasa County were trained but there were inadequate follow up trainings. As was noted from a key informant interview that on-going training for CHCs members was rarely conducted (CHA Mvita sub-County).

"*They have not (CHC members) received any follow up training. Most of the trainings we have done are for specific programmes (TB, HIV…..) and they target selected community health volunteers who are later supposed to perform some activities within their households with support by partners*".

Table 4.5 shows the numbers of CHC members who received training, the organization which supported the training and the duration of the training.

Table 4.5

Descriptive Results for Training in CHC

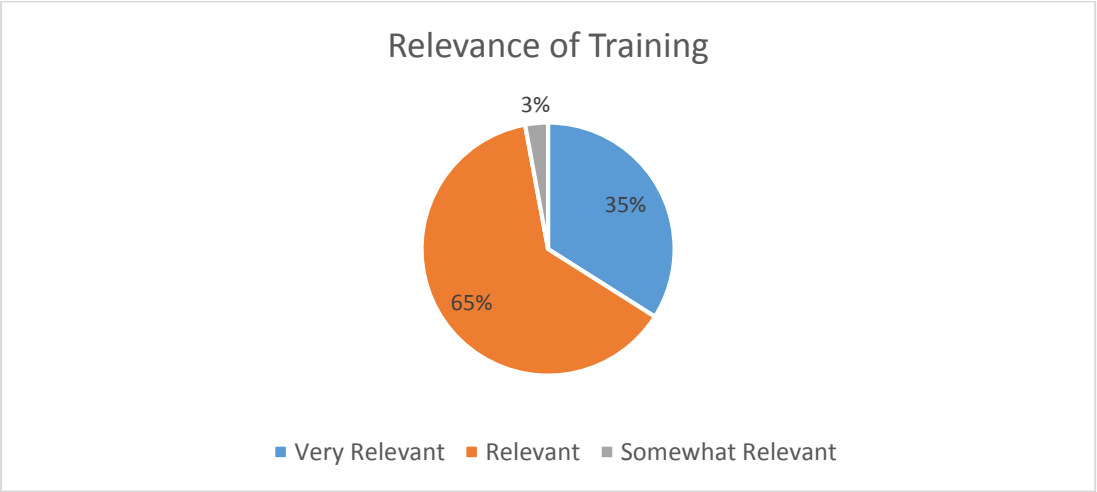
		Frequency	Percent
Receive formal training for your role as a CHC	Yes	154	95.1
	No	8	4.9
	Total	162	100
Organization that supported training	MoH	34	22.2
	Partners	120	77.8
	Total	154	100
Length the training	One week	138	89.5
	Two weeks	16	10.5
	Total	154	100

The results in Table 4.5 further show that 154 (95.1%) of the respondents agreed that they receive trainings which was supported by partners (77.8%) and MoH at 22.2%. The results further show that 89.5% indicated that their training lasted for one week while 10.5% indicated they were trained for two weeks.

The study further sought to establish the relevance of the training the member of community health committees in Mombasa received.

Figure 4.13

Training relevance in relation to expected Functions

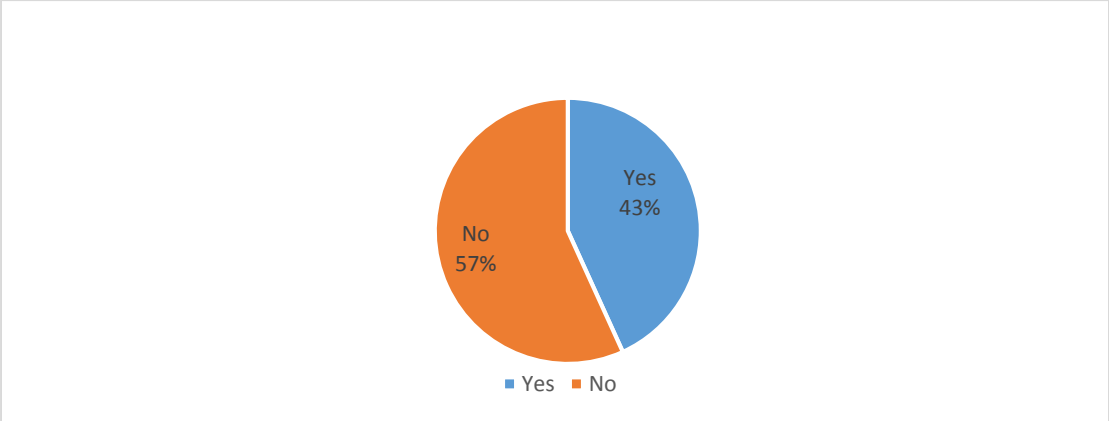


The results presented in Figure 4.13 show that the majority 62% agreed that the training was very relevant with another 35% indicated it was relevant. The majority of CHC (97%) felt that the training they received was relevant.

The respondents were asked whether they were satisfied with the scope of the training and Figure 4.14 shows the results of findings.

Figure 4.14

Satisfaction with Scope of the Training Provided



The result in Figure 4.14 also shows that 66 (43%) of the respondents were satisfied that the training covered relevant scope with 88 (57%) disagreeing that not everything they were expected to do was covered during the training sessions. The finding implied that even though the training members of CHC underwent was relevant, it failed to cover everything to the expectation of all the members. .

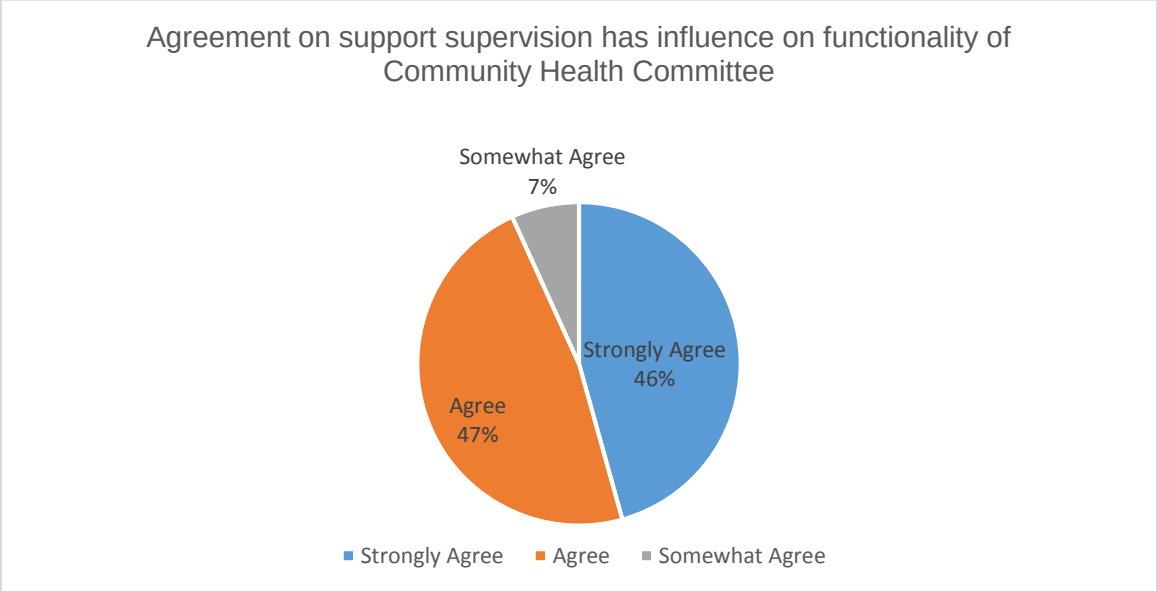
Supervision in Community Health Communities

The study further sought to explore role of support supervision in influencing the functionality of community health communities in Service delivery in Mombasa County. The extent to which CHC members receive supervision from the MOH and/or through other mechanisms to enable the CHC to reach its objectives and fulfill its mission was

assesed. The respondents were asked whether support supervision influence the functionality of the community health committees and Figure 4.15 shows the results of findings.

Figure 4.15

Whether Support Supervision Influence Functionality of CHC



The results in figure 4.15 show that 46% and 47% of the respondents strongly agreed and agreed respectively. The finding implied that the majority of the respondents were of the opinion that support supervision influenced functionality of CHC in Mombasa County.

The study further sought to establish whether there was support supervision to the CHC and frequency of such support supervision.

Table 4.6

Existence and Frequency of Supervision to CHC

Frequency of supervision	Frequency	percentage
None (no supervision)	82	50.6%
Once every 6 months	29	17.9%
Once every 4 Months	41	25.3%
Once every 3 months	10	6.2%
Total	162	100%

The results in Table 4.6 show that 80 (50%) respondents agreed that there were support supervision in their CHC. Out of which 29 indicated once after 6 months, 41 indicated once every 4 months, while 10 indicated once every 3 months. These findings implied that supervision was not available for all the CHC in Mombasa. For those that supervision was done, the frequency varied from one CHC to another with the majority being done after 4 months. The study further asked the respondent whether they had a designated officer who conducts support supervision for Community Health Committees and Table 4.7 shows the results of findings .

Table 4.7

Descriptive Results for Support Supervision

n=162	Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree
A designated officer who conducts support supervision for Community Health Committees.	4.40%	37.70%	6.30%	43.40%	8.20%
There is county guidelines on supervision of Community Health Committee	1.20%	48.20%	20.50%	26.50%	3.60%

The results in Table 4.7 show that 70 (43.4%) and 13(8.20%) agreed and strongly agreed respectively. On the other hand, 61(37.7%) and 7(4.4%) disagreed and strongly disagreed respectively. The finding implied that not all the CHC in Mombasa County were aware of the existence a designated officer who conducts support supervision.

On whether, there were county guidelines on supervision of community health committees, the results show that 39(48.2%) disagreed while 21(26.5%) agreed. The study finding implied that level of awareness on existence of county guidelines of supervision of CHC varied among the respondents. Some respondents were not aware of the existence of supervision guideline while others were well aware. This could imply that the use of supervision checklist by the CHAs was not consistent. According to the CHC training manual, Community Health Assistants (CHAs) are designated as the supervisors for the CHC and is also a secretary to the CHC. This gives the CHAs an opportunity to mentor, motivate and give feedback to the Community Health Committee. During a key informant interview, one CHA indicated that they faced a number of challenges and are under supported;

" *I am responsible for two community units, I have to visit all the CHVs who are undertaking activities in specific projects and compile a report every month. Sometimes I visit the CHC but sometimes due to lack of transport, it may take a longtime before I meet them".*

The findings indicate that supervision was considered to be very important in the functioning of CHC. However, in practice, supervision of CHC was either not done or infrequent.

Functionality of Community Health Communities in Service Delivery

In this section, analysis of functionality of community health committees is conducted. The results are presented in Table 4.8.

Table 4.8

Descriptive Results for Functionality of Community Health Communities in Service Delivery

	Strongly Agree	Agree	Somewhat Agree	Disagree	Strongly Disagree
Committee has prepared a work plan	6.8%	34.0%	4.9%	54.3%	0.0%
Committee reviews and approves annual performance goals	2.5%	37.0%	0.0%	60.5%	0.0%
Community health committee has a current written action plan for the community health unit clearly stating the activities	0.0%	23.5%	4.9%	71.6%	0.0%
Community health committee meets each month	0.0%	49.7%	5.6%	42.9%	1.9%
Community health committee leads quarterly dialogue days with CHVS and community members.	4.9%	47.5%	11.1%	36.4%	0.0%

On whether the community had prepared a work plan, 54% of the respondent disagreed while 39.5% agreed. The finding implied that not all the CHC in Mombasa County had a prepared work plan. The results further show that majority 60% disagreed on whether their CHC reviews and approves annual performance goals. Similarly, the results show that 71.6% of the respondent disagreed on whether their community health committee had a current written action plan for the community health unit clearly stating the activities. On whether there were monthly meetings, 49.7% of the respondents agreed while 42.9% disagreed. The finding implied that some CHC in Mombasa County did have monthly meeting while others monthly meetings was not a sure thing. Finally, the study sought to

find out whether community health committee led quarterly dialogue days with CHVS and community members. The results show that 47.5% and 4.9% strongly agreed and agreed respectively while 36.4% disagreed. The finding in this section implied that not all the CHC in Mombasa County were functional

Some of the challenges highlighted by those interviewed include, lack of supports and lack of recognition by County Government officials and community members. One of the members noted that ;

‘*’Most of the CHC members feel that they are not recognized. They also feel that they are left out in most of the activities within the community unit and this has contributed to the high drop out. In some of the community units the CHC members also serve as community health volunteers since they feel that through this they would be recognized’’*.

4.6 Correlation Analysis

This section presents the correlation matrix which was to test the nature and strength of the association between independent variables and the dependent variable. Pearson correlation (r) ranges from -1 to +1 where values above -/+ 0.50 imply strong positive or negative correlation.

Table 4.9

Correlation Matrix

		Communication	Composition	Training	Support Supervision	Functionality of CHC
Communication	r	1				
Composition	r	.549**	1			
Training	r	.617**	.552**	1		
Support Supervision	r	.622**	.438**	.469**	1	
Functionality of CHC	r	.604**	.623**	.514**	.536**	1
	Sig.	0.000	0.000	0.000	0.000	
	N	162	162	162	162	162

** Correlation is significant at the 0.01 level (2-tailed).

The results in Table 4.9 show that correlation between communication and functionality of CHC was r= 0.604 (p=0.000) which imply that communication had strong positive and significant correlation with functionality of CHC. The findings further implied that improving communication among members/community would improve the functionality of CHC in Mombasa County.

The results also show that correlation between composition and functionality of CHC was r= 0.623 (p=0.000) which also implied that composition had strong positive and significant correlation with functionality of CHC. The findings further implied that improving composition would improves the functionality of CHC in Mombasa County.

The result in Table 4.9 show the correlation between training and functionality of CHC was r=0.514, p=0.000 which also confirmed that training had a moderate, positive and significant association with functionality of CHC. Finally, supervision and functionality of CHC had a correlation of r= 0.536 p=0.000 which further implied that supervision was positively and significantly associated with functionality of CHC.

4.7 Univariate Regression Analysis

This section presents the results of univariate regression analysis between each independent variables and dependent variables. Univariate regression was conducted to test the effect of each independent variables, other variables held constant.

Role of Communication on Functionality of Community Health Committees

The results presented in Table 4.10 shows the univariate analysis between communication and functionality of community health committees.

Table 4.10

Univariate regression for Communication and Functionality of CHC

	B	Std. Error	Beta	t	Sig.
(Constant)	5.362	0.501		10.694	0.000
RoC Score	0.383	0.04	0.604	9.592	0.000
Model	1				
R	.604a				
R Square	0.365				
Adjusted R Square	0.361				
Std. Error of the Estimate	1.2				
F	92.012				
Sig.	.000b				

a Dependent Variable: FxScore

The results presented in Table 4.10 shows that communication accounted for 36.5% (R-square=0.365) of the functionality of the community health committees' other factors held constant. The results further indicated that role of communication on functionality of community health committees was significant (β=0.383, p=0.000).

Role of Composition on Functionality of Community Health Committees

The results presented in Table 4.11 shows the univariate analysis between composition and functionality of community health committees.

Table 4.11

Univariate regression for Composition and Functionality of CHC

	B	Std. Error	Beta	t	Sig.
(Constant)	3.977	0.613		6.49	0.000
EoCScore	0.715	0.071	0.623	10.086	0.000
Model	1				
R	.623a				
R Square	0.389				
Adjusted R Square	0.385				
Std. Error of the Estimate	1.177				
F	101.717				
Sig.	.000b				

a Dependent Variable: FxScore

The results show that composition accounted for 38.9% (R-square=0.389) of the functionality of the community health committees' other factors held constant. The results further indicated that role of composition on functionality of community health committees was significant (β=0.715, p=0.000).

Role of Training on Functionality of Community Health Committees

The results presented in Table 4.12 shows the univariate analysis between training and functionality of community health committees

Table 4.12

Univariate regression for Training and Functionality of CHC

	B	Std. Error	Beta	t	Sig.
(Constant)	3.175	0.918		3.458	0.001
RoTScore	0.598	0.079	0.514	7.573	0.000
Model	1				
R	.514a				
R Square	0.264				
Adjusted R Square	0.259				
Std. Error of the Estimate	1.292				
F	57.351				
Sig.	.000b				

a Dependent Variable: FxScore

The results in this section show that training accounted for 26.4% (R-square=0.264) of the functionality of the community health committees' other factors held constant. The results further indicated that role of trainings on functionality of community health committees was significant (β=0.598, p=0.000).

Role of Support Supervision on Functionality of Community Health Committees

The results presented in Table 4.13 shows the univariate analysis between supervision and functionality of community health committees

Table 4.13

Univariate regression for Support Supervision and Functionality of CHC

	B	Std. Error	Beta	t	Sig.
(Constant)	5.89	0.532		11.08	0.000
Supp Sup Score	0.518	0.064	0.536	8.038	0.000
Model	1				
R	.536a				
R Square	0.288				
Adjusted R Square	0.283				
Std. Error of the Estimate	1.271				
F	64.603				
Sig.	.000b				

a Dependent Variable: FxScore

The results in this section show that support supervision accounted for 28.8% (R-square=0.288) of the functionality of the community health committees' other factors held constant. The results further indicated that role of support supervision on functionality of community health committees was significant (β=0.518, p=0.000). The finding implied that increasing support supervision would significantly improve the functionality of the community health committees' other factors held constant.

4.8 Multivariate Regression Analysis

The study conducted a multivariate regression analysis to test the influence of communication, composition, training and support supervision on functionality of CHC in Mombasa County.

Table 4.14

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.717a	0.514	0.502	1.06

a. Predictors: (Constant), Support Supervision, Composition, Training, Communication

The results of R-square shown in Table 4.14 indicates that jointly communication, composition, training and support supervision accounted for 51.4% of the variation in functionality of CHC in Mombasa County. The finding implied that these factors had high explanatory power on functionality of CHC in Mombasa County.

Table 4.15 show the result of ANOVA which test the significance of the overall regression model used to predict the influence of communication, composition, training and support supervision on functionality of CHC in Mombasa County.

Table 4.15

ANOVA

Model	Sum of squares	df	Mean Square	F	Sig.
Regression	186.486	4	46.622	4.517	0.000[b]
1 Residual	176.304	157	1.123		
Total	362.790	161			

a. Dependent Variable: Functionality of Community Health Communities
b. Predictors: (Constant), Support Supervision, Composition, Training, Communication

The result shows the F-statistics =41.517 p=0.000 which implied that the regression model was statistically significant. The findings show the model had a goodness of fit.

Table 4.16

Regression Coefficients

Table 4.16 ***show the regression coefficients of the independent variables***.

	Unstandardized Coefficients		Standardized coefficients		
Model	β	Std. Error	Beta	t	Sig.
(Constant)	2.120	0.782		2.710	0.007
Communication (RoC)	0.150	0.052	0.236	2.852	0.005
1 Composition (EoC)	0.422	0.081	0.368	5.202	0.000
Training (RoT)	0.155	0.219	0.065	0.708	0.002
Support Supervision (RSS)	0.186	0.070	0.193	2.676	0.008

a. Dependent Variable: Functionality of Community Health Communities

Communication had a coefficient of β=0.150, p=0.005. The coefficient was statistically significant at 5 percent significance level. These results therefore implied that communication had a positive and significant influence on functionality of CHC. The finding further implied that increasing communication by one unit would result to increase in 0.150 units in functionality of CHC.

The result also show that composition had a coefficient of β=0.422, p=0.000. The coefficient was also statistically significant at 5 percent significance level. These results therefore implied that composition had a positive and significant influence on functionality of CHC. The finding further implied that increasing composition by one unit would result to increase in 0.422 units in functionality of CHC.

Training had a coefficient of β=0.155, p=0.002. The coefficient was also statistically significant at 5 percent significance level. These results therefore implied that the role of training was positive and significant on functionality of CHC. The finding further implied

that increasing training of committee members would result to increase in 0.155 units in functionality of CHC.

Finally, support supervision had a coefficient of β=0.186, p=0.008. The coefficient was also statistically significant at 5 percent significance level. These results therefore implied that the role of support supervision was also positive and significant on functionality of CHC. The finding further implied that increasing supervision of community health committees in Mombasa County would result to increase in 0.186 units in functionality of CHC.

Therefore, the regression model $Y_{olk} = \beta_0 + \beta_{roc}X_{roc} + \beta_{eoc}X_{eoc} + \beta_{rot}X_{rot} + \beta_{rss}X_{rss} + \ell i$

Became; Y_{olk} =2.120+ 0.150 (RoC) + 0.422 (EoC) +0.155 (RoT) + 0.186 (RSS) + Ɛ

RoC = role of communication

EoC= effect of composition

RoT= role of training

RSS= role of support supervision

Ɛ = is the error term

CHAPTER FIVE:

SUMMARY, CONCLUSION & RECOMMENDATIONS

5.1 Introduction

This chapter covers the summary of the findings, conclusion and recommendation made by the study. The summary of the findings was presented based on the specific objectives of the study which was to determine the influence of communication, composition, training and supervision on functionality of CHC in Mombasa County. The conclusion and recommendation made by the study were purely derived from the study findings. A summary of the findings and the conclusion for each of the objectives are detailed in the next section

5.2 Summary of the Findings

Communication and Functionality of CHC

The first objective was to examine the role of communication in influencing the functionality of Community Health Committees in Mombasa County. The regression coefficients for Communication was β=0.150, p=0.005. The coefficient was statistically significant at 5 percent significance level. These results therefore implied that communication had a positive and significant influence on functionality of CHC. The study also found that the level of communication among most of Community Health Committees in Mombasa County was low given that not all the members were informed on the plans and progress of their Community Health Committees and few community members attended dialogues that are avenues used by most Community Health Committees in communication. This is supported by previous studies for instance Mireku et al,. (2014) indicated that some community members did not attend the dialogue days, which hampered communication and coordination. As outlined in the theoretical model,

developing team performance is dependent on the teams convening and communicating easily and frequently (Katzenbach, Smith, 1993). Poor community attendance negatively affects the effective functioning of the committee since improving health through behavior change is key.

Composition and Functionality of CHC

The second objective of the study was to assess the effect of composition in influencing the functionality of Community Health Committees in Health Service delivery in Mombasa County. Composition had a coefficient of $\beta=0.422$, $p=0.000$. The coefficient was also statistically significant at 5 percent significance level. These results therefore implied that composition had a positive and significant influence on functionality of CHC. This finding agreed with Loewenson et al (2014) who also noted that the composition of the health committees affect their ability to deliver on the roles as they bring different skills and interests to the committee.

The study also established that not all the CHC in Mombasa County are properly composed or representative of all interest groups. There is a high attrition rate within the CHC with only 4 % having the requisite membership.. The high drop out within the committees may lead to suboptimal community representation and could explain why some of the community health committees become dysfunctional. A functional CHC must represent the interest of all stakeholders and the inadequate representation among some CHC in Mombasa County can negatively affect the functionality. The literature also questions the representativeness of HCCs in relation to the diverse groups and interests in communities (Howard et al., 2002;Jeppsson & Okuonzi, 2000). Murphy et al. (1998) argued, that larger groups offer opportunities for more diverse membership which, when

managed well, lead to better performance. They are also more reliable, enhance credibility and widespread acceptance and implementation of decisions. They concluded that below six participants, reliability diminishes rapidly .

Most of the committee members were appointed (75%). The CHC training manual documents an election process by the community members.. Democratic election processes promote community participation and allow community members to hold community representatives accountable for a more community-oriented healthcare system (Boulle, 2007). On the other hand appointment sometime create avenue that reduce transparency and fairness in composition of the CHC. This lack of transparency and fairness may lead to selection of unfit members to the committees therefore influencing the functionality since the unfairly selected members serve their masters interest instead of the community interests.

This study concluded that the presence of diverse membership gives CHC a greater leverage in addressing community issues resulting in better performance and functionality. Without adequate representation communities health priorities may not be fully addressed

Training and Functionality of CHC

The study further sought to analyze role of training in influencing the functionality of Community Health Committees in Mombasa County. Training had a coefficient of $\beta=0.155$, $p=0.002$. The coefficient was also statistically significant at 5 percent significance level The study established that Training had a positive and significant influence on functionality of CHC. The findings also showed that most community health committees members were trained on their expected duties and roles even though some

felt the training failed to meet their expectation in terms of the scope of the trainings. It was established that apart from the initial training, there was minimal follow up trainings for the committee members. On the contrary, Creigler et al. (2011) noted that there should have initial training to prepare them for their role and an ongoing training for update on new skills, reinforce initial training and ensure that they are practicing the skills learned.

Training provides the CHC with the necessary skills and competencies to provide service oversight or community feedback thereby contributing to optimal functioning of CHC. Adult learning methods are used to build participatory, decision making and problem solving skills The study established that the trainings conducted were participatory. The training system should be responsive to the fact that the CHC is made up of members with different levels of intelligence and formal education..The initial trainings were mostly supported by partners however, over reliance on partners support results into sustainability challenges especially when there is decline in donor support.

Supervision and Functionality of CHC

The study further sought to explore role of support supervision in influencing the functionality of community health communities in Mombasa County. Supervision had a coefficient of $\beta=0.186$, $p=0.008$. The coefficient was also statistically significant at 5 percent significance level. The results show that supervision had a significant influence on functionality of community health communities. The finding further implied that increasing supervision of community health committees in Mombasa County would result to increase in functionality of CHC. It was established that only half of the CHC were supervised with supervision being conducted infrequently. Previous studies supports this finding Mathauer and Imhoff (2006) reported that supervision was infrequent, irregular,

and lacking in feedback. This is also reflected as the situation in Malawi, where the challenge was regular supervision (Kadzindira & Chilowa, 2001). Boulle (2007) found that due to limited staffing, there was limited supervision and support for CHCs. It was established that where supervision was lacking, it was due to poorly coordinated entities which provided inadequate support. Inadequate supervision contact may affect the performance of the CHC According to Freeman et al. (2009) supportive supervision provided by community health field officers is essential in order to maintain the quality of community-based interventions, including health promotion, which CHVs provide. Similarly, Jaskiewicz and Tulenko (2012) argue that supportive supervision was a critical factor in creating and maintaining an enabling work environment

Discussion

Community Health committees are critical aspects of leadership and governance of health systems in Kenya. Functionality of these committees is essential in achieving quality service delivery. The results of these study show that when community health committees are properly composed, adopt effective communication, are properly trained and have support supervision they will increase their functionality and improve overall leadership and governance of health systems by county government in Kenya. The study established that communication has a significant influnce on functionality.However, it was established that information flow was poor with few community members attending community dialogue days where CHC can collect information. This concurs with previous study by Karuga et al. (2019) who also reported that CHCs had little control over the flow of health-related information. It emerged that CHCs were often left out in the flow of health-related information and decision-making, which led to demotivation. In

another similar study, Mireku et al, (2004) reported that some community members did not attend the dialogue days, which hampered communication and coordination. Similarly, two important studies revealed that as one of the work conditions, internal communication strongly influences the engagement and performance of employees (EASHW 2010, Yates, 2006). From this study, information flow from the community to the committee was poor as it was established that community members did not attend community dialogues in good numbers. It was further established that community health assistants get information from the households through community volunteers, however this information may not reach all the CHC since monthly committee meetings are conducted in only 49.7% of the committees.The poor internal communication may contribute to poor coordination and performance of the committee members..

The study established that members composition positively affect the functionality of CHC. This supports Loewenson et al (2014) who concluded that composition of the health committees can affect their ability to deliver on the roles as they bring different skills and interests to the committee. However this study established that the committees have poor representation. One indication of this was the very high attrition rate among the CHC members. Inadequate representation will affects the ability of the committee to undertake their roles effectively and this may lead to a dysfunctional committee. Most of the CHC members were appointed and therefore they may not be accountable to the community, this may further affect community participation. This is supported by Paradath and Friedman, (2008) and Poku, (2008) who argued that some of the CHC lack representativeness which impacts on their functionality.

Health committee members need relevant skills necessary to effectively carry out their roles. Majority of the CHC memebers perceived the training they received to be relevant. The scope of the training they received did not however cover adequately all the skills they need to perform their roles. There was also limited follow up training of the CHC beyond the initial training. This finding is contrary to Creigler et al. (2011) who noted that there should be initial training to prepare them for their role and an ongoing training for update on emerging skills, strengthening previously acquired training and making sure that the learned skills are being practiced. There is need to further asses the areas of knowledge gap for CHC and re-design the training programme or schedule on-going training for the committee to enable them to fully undertake their oversight role in community health services.

The community health manual recommends supervision of CHC. Gaudrault et al. (2016) recommended that supervision should be regular with appropriate tools to enable the CHC to discuss goals, data and performance challenges as well as offer on job training. The finding in this study revealed that half of the CHC have not been surpervised and the supervision is irregular. This can be interpreted to mean that CHC miss out on opportunity to discuss the performance challenges and get on the job training through the supervisor..

5.3 Conclusion

Based on the research findings it can be concluded that in Mombasa County the functionality of community health committee is greatly influenced by communication, composition, training and supervision . Information flow in most health committees was poor with only 32.7% of the community members attending the community dialogue

days. The health committees are not properly composed with majority having less than the requisite committee membership. While majority of the committee members had undergone training, the scope of the training they received did not cover adequately all the skills they need to perform their roles. There was inadequate follow up training with only 43.9% having received any additional training. The study also established that support supervision was inadequate and infrequent with only half of the health committees reporting that they have been supervised.

Health committees are intended to serve as a link between the health services and the communities they serve. These committees must be empowered in terms of trainings, have composition diversity, well coordinated regular supervision and effective channels of communication in order to effectively carry out their functionality as demonstrated by the study findings

5.4 Recommendations

Based on the findings, the following recommendation were made by the study;

1. First to enhance communication, the CHC assisted by the Health Department should conduct awareness campaigns to educate the public on the need to attend dialogue days and other forums where communication can be enhanced for quality service delivery by the community health committees. All the data generated by Community health volunteers from household visits should be channeled through the CHC to strengthen their oversight role. When creating new Community units, Community members should be engaged early for support and buy-in.

2. The Department of Health should develop strategies to enhance community representation and sustainability of the Community Health Committees. Consideration

should be given to compensation of CHC members with transport refund during their meetings. Alternatively, the Health Facility Committee which has a fairly similar composition could take up the oversight role of the Community Health Strategy, since the Health Facility Committees already have an incentive structure through payment of meeting allowance, they would be more sustainable.

3. The Ministry of Health training program for CHC should be re-designed with provisions for periodic refresher trainings to improve their knowledge and skills. Corresponding resources should be provided to facilitate the additional trainings.

4. Finally, County Government of Mombasa should strengthen supervision and mentoring of the CHC to ensure they function according to their terms of engagement for maximum and effective service delivery. The sub-county community health focal person should ensure that the activities of the CHA are well coordinated and that a standardized supervision tools is developed and used during supervision. The use of mobile phone for support supervision, in addition to face to face meeting, could address the challenge of transport expenses. Providing resources for supervisor phone vouchers to stay in contact with their CHC members would greatly enhance supervision.

5.5 Areas for Further Research

There are many factors that affect the functionality of the Community Health Committees, this study focused on only four factors which include Communication, Composition, Training and Supervision. Further studies should seek to identify other factors besides those covered in this study. This study found that most of the CHC members were not satisfied with the scope of the training however specific areas where

the training gaps exist was not outlined in this study, therefore further study can help to identify areas for refresher trainings.

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APPENDICES

Appendix I: Consent Form

Shem Patta

P.O. BOX 90233-80100

MOMBASA

Kenya Methodist University
P. 0 Box 267-60200
MERU, Kenya

SUBJECT: INFORMED CONSENT

Dear Respondent,

My name is Shem Patta, I am a MSc student from Kenya Methodist University. I am conducting a study titled: "***Factors That Influence the functionality of Community Health Committees in Mombasa County."*** This research proposal is critical to strengthening health systems as it will generate new knowledge in this area that will inform decision makers to make decisions that are evidence based.

Procedure to be followed:

Participation in this study will require that I ask you some questions and also access all the hospital's department to address the six pillars of the health system. Participation in this study will require that I ask you some questions and I will record the information in a questionnaire check list.

You have the right to refuse participation in this study. You will not be penalized nor victimized for not joining the study and your decision will not be used against you nor affect you at your place of employment.

Please remember that participation in the study is voluntary. You may ask questions related to the study at any time. You may refuse to respond to any questions and you may stop an interview at any time. You may also stop being in the study at any time without any consequences to the services you are rendering.

Discomforts and risks

Some of the questions you will be asked are on intimate subject and may be embarrassing or make you uncomfortable. If this happens; you may refuse to answer if you choose. You may also stop the interview at any time. The interview may take about 40 minutes to complete.

Benefits

If you participate in this study you will help us to strengthen the health systems in Mombasa County, Kenya as a country and other low-in- come countries in Africa. As a result, countries, communities and individuals wasnefit from improved quality of healthcare services. This field attachment is critical to strengthening the health systems as it will generate new knowledge in this area that will inform decision makers to make decisions that are evidence based.

Rewards

There is no reward for anyone who chooses to participate in the study.

Confidentiality

The interviews was conducted in a private setting within the institution. Your name will not be recorded on the questionnaire and the questionnaires was kept in a safe place at the University.

Contact Information

If you have any questions you may contact my supervisors whose names and contacts are as follows:

Mr. Musa Oluoch

Department of Health Systems Management

Kenya Methodist University

Mr. Ben Onyango-Osuga

Department of Health Systems Management

Kenya Methodist University

Participant's Statement

The above statement regarding my participation in the study is clear to me. I have been given a chance to ask questions and my questions have been answered to my satisfaction. My participation in this study is entirely voluntary. I understand that my records was kept private and that I can leave the study at any time.

I understand that I will not be victimized at my place of work whether I decide to leave the study or not and my decision will not affect the way I am treated at my work place.

Date:……. **Signature:**…….

Investigator's Statement

I, the undersigned, have explained to the volunteer in a language s/he understands on the procedures to be followed in the study and the risks and the benefits involved.

Name of Interviewer…… **Date**:…….

Appendix II: Research Questionnaire

To be filled by the researcher and respondents are CHC

Date……../……2020 **Serial No.** ☐

Part 1; **General information**

Q1. Which Community Unit do you serve? …….

Q2. What is the respondent's gender?

Male ☐ b) Female ☐

Q3. What is your age bracket?

under 20 b) 21-30 c) 31-40 d) 41-50 e) over 50

Q4. What is your highest attained education level?

a)Primary ☐ b)Secondary ☐ c)College ☐ d)University ☐ e)Others ☐

Part 2; Role of communication in influencing the functionality of Community Health Committees.

Q5. Communication influences the functionality of CHC.

a) Strongly disagree ☐
b) disagree ☐
c) Neither agree nor disagree ☐
d) agree ☐
e) Strongly agree ☐

Using a scale of 1-5 where 1-strongly disagree, 2- disagree, 3-neither agree nor disagree, 4-agree and 5-strongly agree, kindly indicate your agreement level to the statements below that relate to communication, composition and training of CHC members

Q6.What is your impression about the following regarding communication in your CHC?

	1	2	3	4	5
	Strongly disagree	disagree	Neither agree nor disagree	Agree	Strongly Agree
The level of communication within my CHC is good.(CHC access data from CHW/Health facility & uses the data to make key decisions)					
I am kept well informed about my CHC activities, plans and progress					

Q7. How does your CHC pass or receive information to the community?

a) Dialogue days. ☐
b) Monthly meetings. ☐
c) Community gatherings. ☐
d) Informal meetings. ☐
e) Others (specify) ☐

Q8. There is good community attendance for dialogue days?

a) Not so good ☐
b) No good ☐
c) Somewhat good ☐
d) Good ☐
e) Very Good ☐

Q9. Which communication technology is used to communicate in your CHC?

a) SMS ☐ WhatsApp ☐ b) email ☐ d) Telephone call ☐ e) others ☐

Part 3; Effect of composition in influencing the functionality of Community Health Committees.

Q 10. The composition of CHC members affects the functionality of the CHC.

a) strongly agree ☐

b) Agree ☐

c) Neither agree nor disagree ☐

d) Disagree ☐

e) Strongly disagree ☐

Q11. How many members are there in your Committee…….

Q12. Are there new members who have replaced the initial Committee Members? No ☐ Yes ☐ (specify no_____)

Q13; I consider my committee to be representative of all the interest groups within the community.

a) Strongly agree ☐

b) Agree ☐

c) Somewhat Agree ☐

d) Disagree ☐

e) Strongly Disagree ☐

Q 14. How did you become a Committee member? Election ☐ Appointment ☐

Part 4. **Role of training in influencing the functionality of Community Health Committees**.

Q15. Training of committee members influence the functionality of CHC.

a) Strongly agree ☐

b) Agree ☐

c) Somewhat Agree ☐

d) Disagree ☐

e) Strongly Disagree ☐

Q16..Did you receive formal training for your role as a CHC? Yes ☐ No ☐

Q17. Who supported the training? a) MOH b) Partners _____specify

Q18. How long did the training last? ☐ 1 week ☐ 2 weeks ☐ others (specify)_____

Q19. During my training, the approach used was participatory.

a) Strongly agree ☐

b) Agree ☐

c) Somewhat Agree ☐

d) Disagree ☐

e) Strongly Disagree ☐

Q20. How relevant was the training in relation to the functions you perform?

a) very relevant ☐

b) relevant ☐

c) Somewhat relevant ☐

d) Not so relevant ☐

e) Not at all relevant ☐

Q21. Are there functions which you perform/ expected to perform that were not covered during the training? Yes ☐ NO ☐

Q22.Which functions do you perform that were not covered in training or require further training?

List: a, ……..…… b,…..……..c,…….

Q23. Apart from the initial training, committee members have had refresher training regarding their duties/roles.

a) Strongly disagree ☐
b) disagree ☐
c) Neither Agree nor Disagree ☐
d) Agree ☐
e) Strongly agree ☐

Part 5. **Support supervision in the functionality of Community Health Committees**.

Q24. Support supervision influences the functionality of Community Health Committee?

a) Strongly agree ☐
b) Agree ☐
c) Neither Agree nor Disagree ☐
d) Disagree ☐
e) Strongly Disagree ☐

Q25. Is supervision done to the community health committee? Yes ☐ No ☐

Q26. If yes, how often?

a) Once every 6 months ☐
b) Once every 4 months ☐
c) Once every 3 months ☐
d) Once every 2 months ☐
e) Once every month ☐

Q27. A designated officer conducts support supervision to the Community Health Committees.

a) Strongly disagree ☐

b) disagree ☐

c) Neither Agree nor Disagree ☐

d) Agree ☐

e) Strongly agree ☐

Q28. There are County guidelines on supervision of Community Health Committee

a) Strongly disagree ☐

b) Disagree ☐

c) Neither Agree nor Disagree ☐

d) Agree ☐

e) Strongly agree ☐

Part 6; **Community Health Committee functionality**

Q29. There is an existing process for preparation of committee work plan

a) Strongly agree ☐

b) Agree ☐

c) Neither agree nor disagree ☐

d) Disagree ☐

e) Strongly Disagree ☐

Q30. My Committee reviews and approves annual performance goals for the Community Unit.

a) Strongly agree ☐

b) Agree ☐

c) Somewhat Agree ☐

d) Disagree ☐

e) Strongly Disagree ☐

Q31. The community health committee has a current written action plan for the Community Health Unit clearly stating the activities.

a) Strongly agree ☐

b) Agree ☐

c) Somewhat Agree ☐

d) Disagree ☐

e) Strongly Disagree ☐

Q32. The community health committee consistently meets each month.

a) Strongly agree ☐

b) Agree ☐

c) Somewhat Agree ☐

d) Disagree ☐

e) Strongly Disagree ☐

Q33. Community health committee leads quarterly community dialogue days with CHVs.

a) Strongly agree ☐

b) Agree ☐

c) Somewhat Agree ☐

d) Disagree ☐

e) Strongly Disagree ☐

Q34, what are the 3 main challenges of facing Community Health Committees?

1._____

2._____

3._____

Appendix III; Key Informant Interview Guide

(Community Strategy Focal Person/ Sub-County Medical Officer)

Date of the interview; /…….2020

Name of Officer…… Duration in Current position……

Introduction

My name is Shem Patta from Kenya Methodist University. I am conducting a study on ***Factors Influencing the Functionality of CHC as Governance Structure for Community Health Service Delivery in Mombasa County***.

The study is aimed at evaluating the functionality of the Community Health Committees as governance structure for community health service delivery in Mombasa County. This will identify contextual factors that influence the performance of CHCs in Mombasa County.

The results will inform the development of interventions for improving CHC performance and their contribution to CHS services. Your knowledge was very valuable.

Interview questions.

1. In your view what influences the functionality of Community Health Committees?

_____

_____

_____

2. What is the role of the following factors in ensuring functionality of the community health Committee? (probe on Training, Communication, Support supervision and Composition)

a)Training _____

b)Communication _____

c) Support Supervision_____

d) Composition_____

3. What is the role SCHMT/CHMT in ensuring the functionality of Community Health Committees in Mombasa County?

_____

_____

4. What are the challenges faced by Community Health Committees in undertaking their roles?

_____

5. How can we address the challenges facing Community Health Committees in Mombasa County?

_____

_____

Appendix IV; KEMU Research Authorization letter

KENYA METHODIST UNIVERSITY
P. O. BOX 267 MERU - 60200, KENYA FAX: 254-64-30162
TEL: 254-064-30301/31229/30367/31171 EMAIL: INFO@KEMU.AC.KE

23rd October 2019 KeMU/SERC/HSM/75/2019

Shem Onyango Patta
HSM-3-7349-2/2012
Kenya Methodist University

Dear Shem,

SUBJECT: FACTORS THAT INFLUENCE THE FUNCTIONALITY OF COMMUNITY HEALTH COMMITTEES: A CASE OF MOMBASA COUNTY, KENYA

This is to inform you that Kenya Methodist University Scientific Ethics and Review Committee has reviewed and approved your above research proposal. Your application approval number is KeMU/SERC/HSM/75/2019. The approval period is 23rd October 2019 – 23rd October 2020.

This approval is subject to compliance with the following requirements

I. Only approved documents including (informed consents, study instruments, MTA) will be used.

II. All changes including (amendments, deviations, and violations) are submitted for review and approval by Kenya Methodist University Scientific Ethics and Review committee.

III. Death and life-threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to KeMU SERC within 72 hours of notification.

IV. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to KeMU SERC within 72 hours.

V. Clearance for export of biological specimens must be obtained from relevant institutions.

VI. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal

VII. Submission of an executive summary report within 90 days upon completion of the study to KeMU SERC.

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) https://oris.nacosti.go.ke and also obtain other clearances needed.

Yours sincerely,

KENYA METHODIST UNIVERSITY RESEARCH & DEVELOPMENT P.O. BOX 267-60200, MERU 29 Oct 2019

Dr. A. Wamachi
Chair, SERC

Cc: Director, Postgraduate Studies

Appendix V: NACOSTI Permit

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: 275792

Date of Issue: 03/February/2020

RESEARCH LICENSE

This is to Certify that Dr.. SHEM PATTA of Kenya Methodist University, has been licensed to conduct research in Mombasa on the topic: FACTORS THAT INFLUENCE THE FUNCTIONALITY OF COMMUNITY HEALTH COMMITTEES: A CASE OF MOMBASA COUNTY, KENYA for the period ending : 03/February/2021.

License No: NACOSTI/P/20/3376

275792

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

THE SCIENCE, TECHNOLOGY AND INNOVATION ACT, 2013

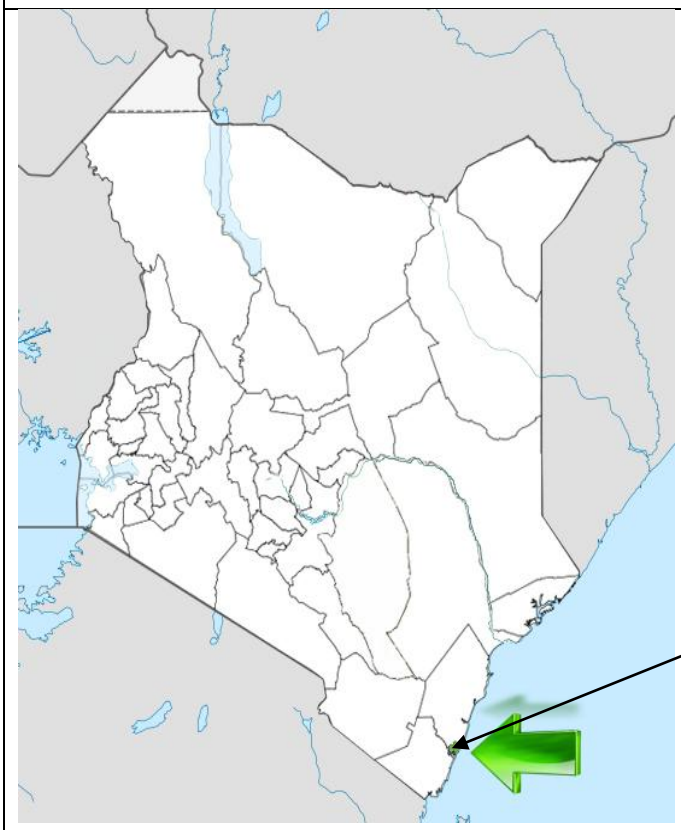
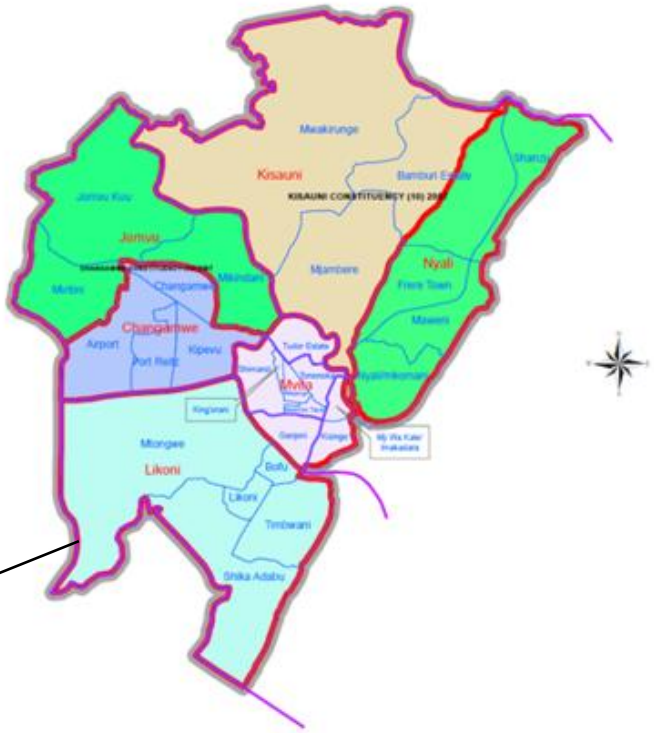
The Grant of Research Licenses is Guided by the Science, Technology and Innovation (Research Licensing) Regulations, 2014

CONDITIONS

1. The License is valid for the proposed research, location and specified period
2. The License any rights thereunder are non-transferable
3. The Licensee shall inform the relevant County Director of Education, County Commissioner and County Governor before commencement of the research
4. Excavation, filming and collection of specimens are subject to further necessary clearence from relevant Government Agencies
5. The License does not give authority to tranfer research materials
6. NACOSTI may monitor and evaluate the licensed research project
7. The Licensee shall submit one hard copy and upload a soft copy of their final report (thesis) within one of completion of the research
8. NACOSTI reserves the right to modify the conditions of the License including cancellation without prior notice

National Commission for Science, Technology and Innovation
off Waiyaki Way, Upper Kabete,
P. O. Box 30623, 00100 Nairobi, KENYA
Land line: 020 4007000, 020 2241349, 020 3310571, 020 8001077
Mobile: 0713 788 787 / 0735 404 245
E-mail: dg@nacosti.go.ke / registry@nacosti.go.ke
Website: www.nacosti.go.ke

Appendix VI: Map of the Study Area

Map of Kenya showing Mombasa county	Map of the six sub-counties in Mombasa county
	

APPENDIX V11; County Authorisation letter

COUNTY GOVERNMENT OF MOMBASA

DEPARTMENT OF HEALTH SERVICES
OFFICE OF THE COUNTY DIRECTOR OF HEALTH

Uhuru Na Kazi Building, 5th Floor
Email: msachd2013@gmail.com

P.O Box 91040 – 80103
MOMBASA

Ref: MSA/CH/ADM.37/VOL.I/50

Date: 28th January 2020

All Sub County Medical Officers of Health
Mombasa County

Dear Sir/Madam

RE: AUTHORIZATION FOR DATA COLLECTION BY SHEM ONYANGO PATTA

The above named is a student pursuing Master of Science Degree in Health Systems Management at Kenya Methodist University. This office has no objection and therefore Permission has been granted for him to collect data for his study:

Topic: "FACTORS THAT INFLUENCE THE FUNCTIONALITY OF COMMUNITY HEALTH COMMITTEES; A CASE OF MOMBASA COUNTY, KENYA".

Kindly accord him the necessary support.

Thank you.

COUNTY DIRECTOR OF HEALTH
P. O. Box 91040 - 80103,
MOMBASA COUNTY.

DR ANISA BAGHAZAL
RESEARCH COORDINATOR
COUNTY DIRECTOR MEDICAL SERVICES
DEPARTMENT OF HEALTH
COUNTY GOVERNMENT OF MOMBASA

APPENDIX VIII; Journal Publication Acceptance Letter

International Journal of Professional Practice

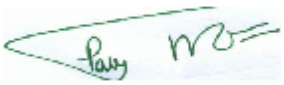
Date: 13th September 2021

Dear: Shem Onyango Patta, Musa Oluoch, Ben Onyango-Osuga

Acceptance Letter

This is to formally inform you that your manuscript entitled….. "*Factors influencing the functionality of community health committees: A case of Mombasa county, Kenya…..*" has been accepted for publication in the **International Journal of Professional Practice (IJPP) of Kenya Methodist University**. After processing and proof correction, your paper will be published in the next available issue.

Thank you for your contribution. On behalf of the members of Editorial Board of International Journal of Professional Practice, we look forward to your continued contributions to the Journal.



Paul Gichohi, Ph.D., Editor in Chief
International Journal of Professional Practice (IJPP)